Washington State Health Care Authority	**WASHINGTON APPLE HEALTH** **2015 MANAGED CARE CONTRACT**	HCA Contract Number: «Contract» Contractor Contract Number: ☒ Competition Exempt

This Contract is between the State of Washington Health Care Authority (HCA) and the Contractor identified below, and is governed by chapter 41.05 RCW, chapter 74.09 RCW and Title 182 WAC.

CONTRACTOR NAME	CONTRACTOR doing business as (DBA)	
«Organization_Name»		
«Mailing_AddressSt_Address» «City», «State» «Zip_Code»	WASHINGTON UNIFORM BUSINESS IDENTIFIER (UBI) «UBI»	HCA INDEX NUMBER

CONTRACTOR CONTACT	CONTRACTOR TELEPHONE	CONTRACTOR E-MAIL ADDRESS
«Contact_Fname» «Contact_LName»	«PhoneNo»	«EmailAddress»

HCA CONTACT NAME AND TITLE	HCA CONTACT ADDRESS
Alison Robbins Section Manager	Post Office Box 45502 Olympia, WA 98504-5502

HCA CONTACT TELEPHONE	HCA CONTACT FAX	HCA CONTACT E-MAIL ADDRESS
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IS THE CONTRACTOR A SUB-RECIPIENT FOR PURPOSES OF THIS CONTRACT?	CFDA NUMBER(S)
No	

CONTRACT START DATE	CONTRACT END DATE	MAXIMUM CONTRACT AMOUNT
January 1, 2015	December 31, 2015	**Per Member Per Month**

EXHIBITS. The following Exhibits are attached and are incorporated into this Contract by reference:

☒ Exhibits (specify): Exhibit A, Rates; Exhibit B, Service Areas; and Exhibit C, Health Home Provisions.

☒ Attachment 1 - Encounter Data/Financial Summary Reconciliation, Form C; and Attachment 2 - Apple Health Quarterly Encounter/General Ledger Reconciliation, Form D

☐ No Exhibits

Approval from the federal Centers for Medicare and Medicaid Services (CMS) is required for this Contract. Should CMS fail to approve this Contract is null and void.

The terms and conditions of this Contract are an integration and representation of the final, entire and exclusive understanding between the parties superseding and merging all previous agreements, writings, and communications, oral or otherwise regarding the subject matter of this Contract, between the parties. The parties signing below represent they have read and understand this Contract, and have the authority to execute this Contract. This Contract shall be binding on HCA only upon signature by HCA.

CONTRACTOR SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

HCA SIGNATURE	PRINTED NAME AND TITLE	DATE SIGNED

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1 DEFINITIONS

1.1 Access to Care Standards (ACS)

"Access to Care Standards (ACS)" means minimum eligibility requirements for Medicaid eligible persons to access mental health services administered through the Department of Social and Health Services.

1.2 Action

"Action" means the denial or limited authorization of a requested service, including: The type or level of service; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services or act in a timely manner as required herein; failure of the Contractor to act within the timeframes for disposition, resolution, and notification of appeals and grievances; or, for a rural area resident with only one Managed Care Organization (MCO) available, the denial of an enrollee's request to obtain services from outside the Contractor's network:

1.2.1 From any other provider (in terms of training, experience, and specialization) not available within the network;

1.2.2 From a provider not part of the network that is the main source of a service to the enrollee, provided that the provider is given the same opportunity to become a participating provider as other similar providers. If the provider does not choose to join the network or does not meet the qualifications, the enrollee is given a choice of participating providers and is transitioned to a participating provider within sixty (60) calendar days;

1.2.3 Because the only Contractor or provider available does not provide the service because of moral or religious objections;

1.2.4 Because the enrollee's provider determines that the enrollee needs related services that would subject the recipient to unnecessary risk if received separately and not all related services are available within the Contractor's network;

1.2.5 The HCA determines that other circumstances warrant out-of network treatment. (42 C.F.R. § 438.400(b)).

1.3 Actuarially Sound Capitation Rates

"Actuarially Sound Capitation Rates" means capitation rates that have been developed in accordance with generally accepted actuarial principles and practices; are appropriate for the populations to be covered and the services to be furnished under the Contract; and have been certified as meeting the requirements of 42 C.F.R. § 438.6(c) by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board (42 C.F.R. § 438.6(c)).

1.4 **Administrative Hearing**

"Administrative Hearing" means an adjudicative proceeding before an Administrative Law Judge or a Presiding Officer that is governed by Chapter 34.05 RCW, the agency's hearings rules found in Title 388 or 182 WAC, or other law.

1.5 **Advance Directive**

"Advance Directive" means a written instruction, such as a living will or durable power of attorney for health care, recognized under the laws of the State of Washington, relating to the provision of health care when an individual is incapacitated (WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, and 489.100).

1.6 **All Payer Claims (APC) Database**

"All Payer Claims Database" means a centralized repository maintained by the Washington Office of Financial Management and encompasses claims data submitted by MCOs.

1.7 **Allegation of Fraud**

"Allegation of Fraud" means an unproved assertion: an assertion, especially relating to wrongdoing or misconduct on the part of the individual. An allegation has yet to be proved or supported by evidence.

An allegation of fraud is an allegation, from any source, including but not limited to the following:

1.7.1 Fraud hotline complaints;

1.7.2 Claims data mining;

1.7.3 Patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

1.8 **Alternative Benefit Plan (ABP)**

"Alternative Benefit Plan (ABP)" means the new, mandatory Medicaid benefits for the newly eligible Medicaid expansion group of non-pregnant adults between ages 19-64 with modified adjusted gross income that does not exceed 138% of the Federal Poverty Level (FPL) established by the federal Patient Protection and Affordable Care Act (ACA) of 2010. For the purposes of this Contract, we refer to this population as Apple Health Adult Coverage – Medicaid Expansion.

1.9 **Ancillary Services**

"Ancillary Services" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy (WAC 182-500-0010).

1.10 **Anniversary Date**

"Anniversary Date" means the first day of January.

1.11 **Appeal**

"Appeal" means a request for review of an action (42 C.F.R. § 438.400(b)).

1.12 **Appeal Process**

"Appeal Process" means the Contractor's procedures for reviewing an action.

1.13 **Capacity Threshold**

"Capacity Threshold" means the capacity to serve at least sixty (60) percent of Apple Health eligibles in a service area in each of the following six critical provider types: hospital, mental health, primary care, pharmacy, obstetrical, and pediatricians.

1.14 **Care Coordination**

"Care Coordination" means an approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers, and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not accidentally duplicated.

1.15 **Care Coordinator**

"Care Coordinator" means a health care professional or group of professionals, licensed in the state of Washington, who is responsible for providing care coordination services to enrollees. Care Coordinators may be:

1.15.1 A Registered Nurse or Social Worker employed by the Contractor or primary care provider; and/or

1.15.2 Individuals or groups of licensed professionals, or individuals working under their licenses, subcontracted by the primary care provider/clinic.

Nothing in this definition precludes the Contractor or care coordinator from using allied health care staff, such as community health workers and others to facilitate the work of the care coordinator.

1.16 **Care Management**

"Care Management" means a set of services, delivered by Care Coordinators, designed to improve the health of enrollees. Care management includes a health assessment, development of a care plan and monitoring of enrollee status, care coordination, ongoing reassessment and consultation and crisis intervention and case conferencing as needed to facilitate improved outcomes and appropriate use of health services, including moving the enrollee to a less intensive level of care management as warranted by enrollee improvement and stabilization. Effective care management includes the following:

1.16.1 Actively assisting enrollees to navigate health delivery systems, acquire self-care skills to improve functioning and health outcomes, and slow the progression of disease or disability;

1.16.2 Utilization of evidence-based clinical practices in screening and intervention;

1.16.3 Coordination of care across the continuum of medical, behavioral health, oral

health, and long-term services and supports, including tracking referrals and outcomes of referrals;

1.16.4 Ready access to behavioral health services that are, to the extent possible, integrated with primary care; and

1.16.5 Use of appropriate community resources to support individual enrollees, families and caregivers in managing care.

1.17 **Centers for Medicare and Medicaid Services (CMS)**

"Centers for Medicare and Medicaid Services (CMS)" means the federal agency within the U.S. Department of Health and Human Services (DHHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid, the Children's Health Insurance Program (CHIP), and health insurance portability standards.

1.18 **Children's Health Insurance Program**

"Children's Health Insurance Program (CHIP)" means a program to provide access to medical care for children under Title XXI of the Social Security Act, the Children's Health Insurance Program Reauthorization Act of 2009, RCW 74.09.470 and WAC 182-505.

1.19 **Children with Special Health Care Needs**

"Children with Special Health Care Needs" means children under 19 years of age who are any one of the following:

1.19.1 Eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;

1.19.2 Eligible for Medicaid under section 1902(e)(3) of the Act;

1.19.3 In foster care or other out-of-home placement;

1.19.4 Receiving foster care or adoption assistance; and/or

1.19.5 Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V of the Social Security Act.

1.20 **Chronic Disease Self-Management Education (CDSME)**

"Chronic Disease Self-Management Education (CDSME)" means programs that enable individuals with multiple chronic conditions to learn how to manage their overall health, symptoms, and risk factors. An example is the Stanford University Chronic Disease Self-Management Program which has been shown in randomized trials to improve symptoms such as pain, shortness of breath and fatigue, improve ability to engage in everyday activities, reduce depression and decrease costly health care such as emergency department visits.

1.21 **Code of Federal Regulations (C.F.R.)**

"Code of Federal Regulations (C.F.R.)" means the codification of the general and permanent rules and regulations (sometimes called administrative law) published in the Federal Register by the executive departments and agencies of the federal government of the United States.

1.22 **Cold Call Marketing**

"Cold Call Marketing" means any unsolicited personal contact by the Contractor or its designee, with a potential enrollee or a current enrollee of another Contracted managed care organization for the purposes of marketing (42 C.F.R. § 438.104(a)).

1.23 **Comparable Coverage**

"Comparable Coverage" means an enrollee has other insurance that HCA has determined provides a full scope of health care benefits.

1.24 **Concurrent Review**

"Concurrent Review" means the Contractor's review of care and services at the time the event being reviewed is occurring. Concurrent review includes an assessment of the enrollee's progress toward recovery and readiness for discharge while the enrollee is hospitalized or in a nursing facility; and may involve an assessment of the medical necessity of tests or procedures while the enrollee is hospitalized or in a nursing facility.

1.25 **Confidential Information**

"Confidential Information" means information that is exempt from disclosure to the public or other unauthorized persons under Chapter 42.56 RCW or other federal or state law. Confidential Information includes, but is not limited to, Personal Information.

1.26 **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

"Consumer Assessment of Healthcare Providers and Systems (CAHPS®)" means a family of standardized survey instruments, including a Medicaid survey used to measure client experience of health care.

1.27 **Continuity of Care**

"Continuity of Care" means the provision of continuous care for chronic or acute medical conditions through enrollee transitions between: facility to home; facility to facility; providers or service areas; managed care Contractors; and Medicaid fee-for-service and managed care arrangements. Continuity of care occurs in a manner that prevents secondary illness, health care complications or re-hospitalization and promotes optimum health recovery. Transitions of significant importance include: from acute care settings, such as inpatient physical health or behavioral (mental health/substance use) health care settings to home or other health care settings; from hospital to skilled nursing facility; from skilled nursing to home or community-based settings; from one primary care practice or medical home to another; and from substance use care to primary and/or mental health care.

1.28 **Continuity of Care Document (CCD)**

"Continuity of Care Document (CCD)" means an electronic document exchange standard for sharing patient summary information. Summaries include the most commonly needed pertinent information about current and past health status in a form that can be shared by all computer applications, including web browsers, electronic medical record (EMR) and electronic health record (EHR) software systems. The industry is already moving toward

the Consolidated CDA (C-CDA) as the emerging industry standard and the clinical exchange of choice.

1.29 **Contract**

"Contract" means the entire written agreement between HCA and the Contractor, including any Exhibits, documents, and materials incorporated by reference. The parties may execute this Contract in multiple counterparts, each of which is deemed an original and all of which constitutes as one agreement. E-mail (electronic mail) transmission of a signed copy of this Contract shall be the same as delivery of an original.

1.30 **Contractor**

"Contractor" means the individual or entity performing services pursuant to this Contract and includes the Contractor's owners, officers, directors, partners, employees, and/or agents, unless otherwise stated in this Contract. For purposes of any permitted subcontract, "Contractor" includes any subcontractor and its owners, officers, directors, partners, employees, and/or agents. In this Contract "Contractor" may also refer to any other MCO contracting with HCA for the Apple Health program.

1.31 **Contracted Services**

"Contracted Services" means covered services that are to be provided by the Contractor under the terms of this Contract.

1.32 **Covered Services**

"Covered Services" means health care services that HCA determines are covered for enrollees.

1.33 **Credible Allegation of Fraud**

"Credible Allegation of Fraud" means the Contractor has investigated an allegation of fraud and concluded that the existence of fraud is more probable than not. (42 C.F.R. § 455.2).

1.34 **Debarment**

"Debarment" means an action taken by a Federal official to exclude a person or business entity from participating in transactions involving certain federal funds, or debarment under chapter 39.26 RCW.

1.35 **Department of Social and Health Services (DSHS)**

"Department of Social and Health Services (DSHS)" means the Washington State agency responsible for providing a broad array of health care and social services. DSHS administrations with which the Contractor may interface include, but are not limited to:

1.35.1 Behavioral Health and Services Integration Administration is responsible for providing mental health services in state psychiatric hospitals and community settings and chemical dependency inpatient and outpatient treatment, recovery and prevention services.

1.35.2 Aging and Long-Term Support Administration is responsible for providing a safe

home, community and nursing facility array of long-term supports for Washington citizens.

1.35.3 Children's Administration is responsible for keeping Washington children safe, strengthening families and supporting foster children in their communities.

1.35.4 Developmental Disabilities Administration is responsible for providing a safe, high-quality, array of home, community and facility-based residential services and employment support for Washington citizens with disabilities.

1.36 **Director**

"Director" means the Director of HCA. In his or her sole discretion, the Director may designate a representative to act on the Director's behalf. Any designation may include the representative's authority to hear, consider, review, and/or determine any matter.

1.37 **Duplicate Coverage**

"Duplicate Coverage" means an enrollee is privately enrolled on any basis with the Contractor and simultaneously enrolled with the Contractor under this Contract.

1.38 **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)**

"EPSDT (Early and Periodic Screening, Diagnosis, and Treatment)" means screening, diagnostic and treatment services covered by Medicaid for children under the age of twenty-one (21) as defined in the Social Security Act (SSA) Section 1905(r) and described in the HCA EPSDT program policy and Provider Guide.

1.39 **Electronic Health Record (EHR)**

"Electronic Health Record (EHR)" means a systematic collection of electronic health information about an individual patient or population. It is capable of being shared across different health care settings. This sharing can occur by way of network-connected, enterprise-wide information systems and other information networks or exchanges. EHRs include a range of data, including demographics, medical history, medication and allergies, immunization status, laboratory test results, radiology images, vital signs, behavioral health and personal statistics like age and weight. EHRs capture the data collected in a traditional health record.

1.40 **Eligible Clients**

"Eligible Clients" means individuals certified eligible by HCA, living in the service area, and eligible to enroll for health care services under the terms of this Contract.

1.41 **Emergency Department Information Exchange™ (EDIE)**

"Emergency Department Information Exchange™" means an internet-delivered service that enables health care providers to better identify and treat high users of the emergency department and special needs patients. When patients enter the emergency room, EDIE can proactively alert health care providers through different venues such as fax, phone, e-mail, or integration with a facility's current electronic medical records.

1.42 **Emergency Fill**

"Emergency Fill" means the dispensing of a prescribed medication to an enrollee by a licensed pharmacist who has used his or her professional judgment in identifying that the enrollee has an Emergency Medical Condition for which lack of immediate access to pharmaceutical treatment would result in (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

1.43 **Emergency Care for Mental Health Condition**

"Emergency Care for Mental Health Condition" means services provided for an individual, that, if not provided, would likely result in the need for crisis intervention or hospital evaluation due to concerns of potential danger to self, others, or grave disability according to Chapter 71.05 RCW.

1.44 **Emergency Medical Condition**

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part (42 C.F.R. § 438.114(a)).

1.45 **Emergency Services**

"Emergency Services" means inpatient and outpatient contracted services furnished by a provider qualified to furnish the services needed to evaluate or stabilize an emergency medical condition (42 C.F.R. § 438.114(a)).

1.46 **Encrypt**

"Encrypt" means to encipher or encode electronic data using software that generates a minimum key length of 128 bits.

1.47 **Enrollee**

"Enrollee" means an individual who is enrolled in managed care through a Managed Care Organization (MCO) having a Contract with HCA (42 C.F.R. § 438.10(a)).

1.48 **Exception to Rule**

"Exception to rule" means a request by an enrollee or a requesting provider to receive a noncovered health care service according to WAC 182-501-0160.

1.49 **External Quality Review (EQR)**

"External Quality Review (EQR)" means the analysis and evaluation of aggregated information on quality, timeliness and access to the health care services that the Contractor or its subcontractors furnish to enrollees (42 C.F.R. § 438.320).

1.50 **External Quality Review Organization (EQRO)**

"External Quality Review Organization (EQRO)" means an organization that meets the competence and independence requirements set forth in 42 C.F.R. § 438.354, and performs external quality review, other EQR-related activities as set forth in 42 C.F.R. § 438.358, or both (42 C.F.R. § 438.320).

1.51 **Facility**

"Facility" means but is not limited to: a hospital, an inpatient rehabilitation center, long-term and acute care (LTAC), skilled nursing facility, and nursing home.

1.52 **Family Connect**

"Family Connect" means an individual who has a family member currently enrolled in Apple Health Managed Care.

1.53 **Federally Qualified Health Center (FQHC)**

"Federally Qualified Health Center" (FQHC) means a community-based organization that provides comprehensive primary care and preventive care, including health, dental and mental health/substance abuse services to people of all ages, regardless of their ability to pay or health insurance status.

1.54 **First Steps Program – Maternity Support Services (MSS)**

"Maternity Support Services" means a component of HCA's First Steps program. This voluntary program is designed to increase access to prenatal care as early in the pregnancy as possible and improve birth outcomes, including low birth weight (Chapter 182-533 WAC).

1.55 **Foundation for Health Care Quality**

"Foundation for Health Care Quality" means a nonprofit organization that sponsors or conducts health care quality improvement programs and evaluation and measurement activities. Among the projects sponsored by the Foundation are: the Bree Collaborative, the Clinical Outcomes Assessment Program (COAP), the Surgery Clinical Outcomes Assessment Program (SCOAP), and the Obstetrics Clinical Outcomes Assessment Program (OBCOAP).

1.56 **Fraud**

"Fraud" means an intentional deception or misrepresentation made by a person (individual or entity) with the knowledge that the deception could result in some unauthorized benefit to him- or herself or some other person. It includes any act that constitutes fraud under applicable Federal or State Law (42 C.F.R § 455.2).

1.57 **Grievance**

"Grievance" means an expression of dissatisfaction about any matter other than an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights (42 C.F.R. § 438.400(b)).

1.58 **Grievance Process**

"Grievance Process" means the procedure for addressing enrollees' grievances (42 C.F.R. § 438.400(b)).

1.59 **Grievance System**

"Grievance System" means the overall system that includes grievances and appeals handled by the Contractor and access to the hearing system (42 C.F.R. § 438, Subpart F).

1.60 **Guideline**

"Guideline" means a set of statements by which to determine a course of action. A guideline streamlines utilization management decision-making processes according to a set routine or sound evidence-based clinical practice. By definition, following a guideline is never mandatory. Guidelines are not binding and are not enforced.

1.61 **Habilitative Services**

"Habilitative Services" means medically necessary services provided to assist the enrollee in partially or fully attaining, learning, keeping, improving, or preventing deterioration of developmental-age appropriate skills that were never present as a result of a congenital, genetic, or early acquired health condition and required to maximize, to the extent practical, the enrollee's ability to function within his or her environment. (WAC 182-545-400).

1.62 **Hardened Password**

"Hardened Password" means a string of at least eight characters containing at least one alphabetic character, at least one number and at least one special character such as an asterisk, ampersand or exclamation point.

1.63 **Health Care Authority**

"Health Care Authority" means the State of Washington Health Care Authority and its employees and authorized agents.

1.64 **Health Care Professional**

"Health Care Professional" means a physician or any of the following acting within his or her scope of practice; an applied behavior analyst, certified registered dietician, naturopath, podiatrist, optometrist, optician, osteopath, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed midwife, licensed certified social worker, licensed mental health counselor, licensed marriage and family therapist, registered respiratory therapist, pharmacist and certified respiratory therapy technician (42 C.F.R. § 438.2).

1.65 **Healthcare Effectiveness Data and Information Set (HEDIS®)**

"Healthcare Effectiveness Data and Information Set (HEDIS®)"means a set of standardized performance measures designed to ensure that health care purchasers and

consumers have the information they need to reliably compare the performance of managed health care plans. HEDIS® also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS® is sponsored, supported, and maintained by National Committee for Quality Assurance (NCQA).

1.66 **Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit Program**

"Healthcare Effectiveness Data and Information Set (HEDIS®) Compliance Audit Program" means a set of standards and audit methods used by an NCQA certified auditor to evaluate information systems (IS) capabilities assessment (IS standards) and a Contractor's ability to comply with HEDIS® specifications (HD standards).

1.67 **Health Technology Assessment (HTA)**

"Health Technology Assessment (HTA)" means a program that determines if health services used by Washington State government are safe and effective. The program examines scientific evidence for new technologies which is then reviewed by a committee of practicing clinicians. The purpose of the program is to ensure medical treatments and services paid for with state health care dollars are safe and proven to work. HTA contracts for scientific, evidence-based reports about whether certain medical devices, procedures and tests are safe and work as promoted.

1.68 **Individual with Special Health Care Needs**

"Individual with Special Health Care Needs" means an enrollee who meets the diagnostic and risk score criteria for Health Home Services; or is a Child with Special Health Care Needs; or has a chronic or disabling condition that meets all of the following conditions:

1.68.1 Has a biologic, psychologic, or cognitive basis;

1.68.2 The enrollee is likely to continue to have the chronic disease or disabling healthcare condition for more than one year; and

1.68.3 Produces one or more of the following conditions stemming from a disease:

1.68.3.1 Significant limitation in areas of physical, cognitive, or emotional functions; or

1.68.3.2 Dependency on medical or assistive devices to minimize limitations of function or activities.

1.69 **Integrated Patient Record/Clinical Data Repository (CDR)**

"Integrated Patient Record/Clinical Data Repository (IPR-CDR)" means a real time database that consolidates data from a variety of clinical sources to present a unified view of a single patient. It allows clinicians to retrieve data for a single patient rather than a population of patients with common characteristics. Typical data types which are often found within a CDR include: CCD, C-CDA, problem lists, clinical laboratory test results, patient demographics, pharmacy information, radiology reports and images, pathology reports, hospital discharge summaries, ICD codes, and progress notes. The use of standard data inputs helps manage the cost and complexity of data contributed by many

different care providers. The CDR will be operated by the HIE on behalf of sponsoring organizations. HCA will be the initial sponsoring organization.

1.70 **Limitation Extension (LE)**

"Limitation Extension (LE)" means a request by an enrollee or the enrollee's health care provider to extend a covered service with a limit according to WAC 182-501-0169.

1.71 **List of Excluded Individuals/Entities (LEIE)**

"List of Excluded Individuals/Entities (LEIE)" means an Office of Inspector General's List of Excluded Individuals/Entities and provides information to the health care industry, patients, and the public regarding individuals and entities currently excluded from participation in Medicare, Medicaid, and all other federal health care programs. Individuals and entities who have been reinstated are removed from the LEIE.

1.72 **Managed Care**

"Managed Care" means a prepaid, comprehensive system of medical and health care delivery, including preventive, primary, specialty, and ancillary health services.

1.73 **Managed Care Organization (MCO)**

"Managed Care Organization (MCO)" means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services to eligible HCA enrollees under HCA managed care programs.

1.74 **Marketing**

"Marketing" means any communication, whether written, oral, in-person (telephonic or face-to-face) or electronic, and includes promotional activities intended to increase a Contractor's membership or to "brand" a Contractor's name or organization. Marketing is communication from the Contractor to a potential enrollee or enrollee with another HCA-Contracted MCO that can be reasonably interpreted as intended to influence them to enroll with the Contractor or to either not enroll or end enrollment with another HCA-contracted MCO.

1.75 **Marketing Materials**

"Marketing Materials" means materials that are produced in any medium, by or on behalf of the Contractor that can be reasonably interpreted as intended as marketing (42 C.F.R. § 438.104(a)).

1.76 **Material Provider**

"Material Provider" means a Participating Provider whose loss would negatively affect access to care in the service area in such a way that a significant percentage of enrollees would have to change their Provider or Contractor, receive services from a non-participating Provider, or consistently receive services outside the service area.

1.77 **Medicaid Fraud Control Unit (MFCU)**

"Medicaid Fraud Control Unit (MFCU)" means the Washington State Medicaid Fraud Control Unit which investigates and prosecutes fraud by health care providers. The MFCU is part of the Washington State Office of the Attorney General.

1.78 **Medically Necessary Services**

"Medically Necessary" means a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering of pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no medical treatment at all (WAC 182-500-0070).

1.79 **Medical Loss Ratio (MLR)**

"Medical Loss Ratio" means the measurement of the share of enrollee premiums that the Contractor spends on medical claims, as opposed to other non-claims expenses such as administration or profits. Additional clarification can be found in the Congressional Research Service report dated August 26, 2014, found here: http://fas.org/sgp/crs/misc/R42735.pdf

1.80 **Mental Health Professional**

"Mental Health Professional" means:

1.80.1 A psychiatrist, psychologist, psychiatric nurse or social worker as defined in Chapter 71.34 RCW;

1.80.2 A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university. Such persons shall have, in addition, at least two years of experience in direct treatment or persons with mental illness or emotional disturbance, such experience gained under the supervision of a Mental Health Professional;

1.80.3 A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

1.80.4 A person who has an approved exception to perform the duties of a Mental Health Professional that was requested by the regional support network and granted by the DSHS Division of Behavioral Health and Recovery before July 1, 2001; or

1.80.5 A person who has been granted a time-limited waiver of the minimum requirements of a Mental Health Professional by the DSHS Division of Behavioral Health and Recovery consistent with WAC 388-865-0265.

1.81 **National CAHPS® Benchmarking Database – (NCBD)**

"National CAHPS® Benchmarking Database – (NCBD)" means a national repository for data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS®). The database facilitates comparisons of CAHPS® survey results by survey sponsors.

Data is compiled into a single national database, which enables NCBD participants to compare their own results to relevant benchmarks (i.e., reference points such as national and regional averages). The NCBD also offers an important source of primary data for specialized research related to consumer assessments of quality as measured by CAHPS®.

1.82 **National Correct Coding Initiative (NCCI)**

"National Correct Coding Initiative (NCCI)" means CMS-developed coding policies based on coding conventions defined in the American Medical Association's CPT manual, national and local policies and edits.

1.83 **National Committee for Quality Assurance (NCQA)**

"National Committee for Quality Assurance (NCQA)" means an organization responsible for developing and managing health care measures that assess the quality of care and services that managed care clients receive.

1.84 **Neurodevelopmental Services**

"Neurodevelopmental services" means a group of community non-profit and hospital-based agencies as designated by the Department of Health who provide therapy and related services to young children with neuromuscular or developmental disorders. Services may include speech, occupational, and physical therapies, along with other specialties such as nutrition, social work, and adaptive equipment.

1.85 **New Individual**

"New Individual" means a person who was not enrolled in an Apple Health managed care program within the six (6) months immediately preceding enrollment, and who does not have a family member enrolled in Apple Health Managed Care.

1.86 **Non-Participating Provider**

"Non-Participating Provider" means a person, health care provider, practitioner, facility or entity acting within their scope of practice and licensure, that does not have a written agreement with the Contractor to participate in a managed care organization's provider network, but provides health care services to enrollees.

1.87 **Office of Inspector General (OIG)**

"Office of Inspector General (OIG)" means the Office of Inspector General within the United States Department of Health and Human Services.

1.88 **OneHealthPort Health Information Exchange (HIE)**

"OneHealthPort Health Information Exchange (HIE)" means the statewide HIE created under Chapter 300, Laws of 2009 (SSB 5501). OneHealthPort is designated by HCA as the Lead HIE Organization for Washington State. The HIE is operated by OneHealthPort under the oversight of HCA and an Oversight Board. The CDR is operated as a service of the HIE. The HIE also delivers connectivity services for a variety of Trading Partners in Washington State and other states. The HIE is the connectivity path for organizations

transacting data with the CDR. Organizations transacting data with the CDR will be required to connect to the HIE in some manner.

1.89 **Overpayment**

"Overpayment" means any payment from HCA to the Contractor in excess of that to which the Contractor is entitled by law, rule, or this contract, including amounts in dispute.

1.90 **Participating Rebate Eligible Manufacturer**

"Participating Rebate Eligible Manufacturer" means any manufacturer participating in the Medicaid Drug Rebate Program and who has a signed National Drug Rebate Agreement with the Secretary of Health and Human Services.

1.91 **Participating Provider**

"Participating Provider" means a person, health care provider, practitioner, or entity, acting within their scope of practice and licensure, with a written agreement with the Contractor to provide services to enrollees under the terms of this Contract.

1.92 **Partnership Access Line (PAL)**

"Partnership Access Line (PAL)" means a resource that provides access to consultation with a child psychiatrist to assist prescribers in meeting the needs of an enrolled child with a mental health diagnosis.

1.93 **Pediatric Concurrent Care**

"Pediatric Concurrent Care" means medically necessary services delivered at the same time as hospice services, to provide treatment leading to a curative state (WAC 182-551-1860) for children 20 years of age and younger.

1.94 **Pediatric Palliative Care**

"Pediatric Palliative Care" means medical care and treatment for children 20 years of age and younger that are not enrolled in Hospice and have a serious and chronic illness that requires pain relief and symptom management rather than cure.

1.95 **Peer-Reviewed Medical Literature**

"Peer-Reviewed Medical Literature" means medical literature published in professional journals that submit articles for review by experts who are not part of the editorial staff. It does not include publications or supplements to publications primarily intended as marketing material for pharmaceutical, medical supplies, medical devices, health service providers, or insurance carriers.

1.96 **Personal Information**

"Personal Information" means information identifiable to any person, including, but not limited to, information that relates to a person's name, health, finances, education, business, use or receipt of governmental services or other activities, addresses, telephone numbers, Social Security Numbers, driver license numbers, other identifying numbers, and any financial identifiers.

1.97 **Physician Group**

"Physician Group" means a partnership, association, corporation, individual practice association, or other group that distributes income from the practice among its members. An individual practice association is a physician group only if it is composed of individual physicians and has no subcontracts with physician groups.

1.98 **Physician Incentive Plan**

"Physician Incentive Plan" means any compensation arrangement between the Contractor and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services to enrollees under the terms of this Contract.

1.99 **Physician's Orders for Life Sustaining Treatment (POLST)**

"Physician's Orders for Life Sustaining Treatment (POLST)" means a set of guidelines and protocols for how emergency medical personnel shall respond when summoned to the site of an injury or illness for the treatment of a person who has signed a written directive or durable power of attorney requesting that he or she not receive futile emergency medical treatment (RCW 43.70.480).

1.100 **Plan Reconnect**

"Plan Reconnect" means an individual who has regained eligibility for Apple Health Managed Care and who was enrolled in Apple Health Managed Care within the six (6) months immediately preceding reenrollment.

1.101 **Postservice Review**

"Postservice review" means the Contractor's review of health care services that have already been received by the enrollee, but were not prior authorized according to Contractor policy.

1.102 **Post-stabilization Services**

"Post-stabilization Services" means contracted services, related to an emergency medical condition and emergency care for a mental health condition that are provided after an enrollee is stabilized in order to maintain the stabilized condition or to improve or resolve the enrollee's condition (42 C.F.R. § 438.114 and 422.113).

1.103 **Potential Enrollee**

"Potential Enrollee" means any individual who HCA determines is eligible for enrollment in Apple Health Managed Care and who, at the time of HCA's determination, is not enrolled with any Apple Health Managed Care Contractor (42 C.F.R. § 438.10(a)).

1.104 **Primary Care Provider (PCP)**

"Primary Care Provider (PCP)" means a participating provider who has the responsibility for supervising, coordinating, and providing primary health care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care. PCPs include, but are not limited to Pediatricians, Family Practitioners, General Practitioners, Internists, Naturopathic physicians, medical residents (under the supervision of a

teaching physician), Physician Assistants (under the supervision of a physician), or Advanced Registered Nurse Practitioners (ARNP), as designated by the Contractor. The definition of PCP is inclusive of primary care physician as it is used in 42 C.F.R. § 438. All Federal requirements applicable to primary care physicians will also be applicable to primary care providers as the term is used in this Contract.

1.105 **Predictive Risk Intelligence System (PRISM)**

"Predictive Risk Intelligence System (PRISM)" means a DSHS-secure web-based predictive modeling and clinical decision support tool. It provides a unified view of medical, behavioral health, and long-term care service data that is refreshed on a weekly basis. PRISM provides prospective medical risk scores that are a measure of expected medical costs in the next 12 months based on the patient's disease profile and pharmacy utilization.

1.106 **Provider**

"Provider" means an individual medical professional, hospital, skilled nursing facility, other facility or organization, pharmacy, program, equipment and supply vendor, or other entity that provides care or bills for health care services or products.

1.107 **Provider Access Payment (PAP) Program**

"Provider Access Payment (PAP) Program" means a federally funded program that provides additional payments to eligible providers.

1.108 **Quality**

"Quality" means the degree to which a Contractor increases the likelihood of desired health outcomes of its enrollees through its structural and operational characteristics and through the provision of health services that are consistent with current professional knowledge (42 C.F.R. § 438.320).

1.109 **Referral Provider**

"Referral Provider" means a provider, who is not the enrollee's PCP, to whom an enrollee is referred for covered services.

1.110 **Regional Support Network (RSN)**

"Regional Support Network (RSN)" means a single or multiple-county authority or other entity operating as a prepaid inpatient health plan through which the agency or the agency's designee contracts for the delivery of community outpatient and inpatient mental health services system in a defined geographic area to enrollees who meet Access to Care Standards.

1.111 **Regulation**

"Regulation" means any federal, state, or local regulation, rule, or ordinance.

1.112 **Revised Code of Washington (RCW)**

"Revised Code of Washington (RCW)" means the laws of the state of Washington. All references in this Contract to RCW chapters or sections shall include any successor, amended, or replacement statute. Pertinent RCW chapters can be accessed at http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx.

1.113 **Risk**

"Risk" means the possibility that a loss may be incurred because the cost of providing services may exceed the payments made for services. When applied to subcontractors, loss includes the loss of potential payments made as part of a physician incentive plan, as defined in this Contract.

1.114 **Safety Net Assessment Fund (SNAF)**

"Safety Net Assessment Fund (SNAF)" means a program that increases payment for hospital claims for Medicaid clients, authorized under Chapter 74.60 RCW.

1.115 **Screening, Brief Intervention and Referral for Treatment (SBIRT)**

"Screening, Brief Interventions and Referral to Treatment (SBIRT)" means a comprehensive, evidenced-based public health practice designed to identify through screening, adolescents and adults who are at risk for or have some level of substance use disorder which can lead to illness, injury, or other long-term morbidity or mortality. If a person is found to be at risk of harm from their use, they receive several brief interventions to reduce their risk or if necessary, a referral for further evaluation for treatment. SBIRT services are provided in a wide variety of medical and community health care settings: primary care centers, hospital emergency rooms, and trauma centers.

1.116 **Second Opinion Network (SON)**

"Second Opinion Network (SON)" means an organization consisting of Agency recognized experts in the field of child psychiatry contracted with by HCA to perform peer-to-peer medication reviews with health care providers when psychotropic medications or medication regimens for children under eighteen (18) years of age exceed the medications review thresholds established for the HCA Medicaid mental health benefit.

1.117 **Secured Area**

"Secured Area" means an area to which only authorized representatives of the entity possessing the Confidential Information have access. Secured Areas may include buildings, rooms or locked storage containers (such as a filing cabinet) within a room, as long as access to the Confidential Information is not available to unauthorized personnel.

1.118 **Service Areas**

"Service Areas" means the geographic areas in which the Contractor serves eligible clients as described in this Contract.

1.119 **Single Case Agreement**

"Single Case Agreement" means a written agreement between the Contractor and a nonparticipating provider to deliver services to an enrollee.

1.120 **Subcontract**

"Subcontract" means any separate agreement or Contract between the Contractor and an individual or entity ("Subcontractor") to perform all or a portion of the duties and obligations that the Contractor is obligated to perform pursuant to this Contract.

1.121 **Substantial Financial Risk**

"Substantial Financial Risk" means a physician or physician group as defined in this Section is at substantial financial risk when more than twenty-five percent (25%) of the total maximum potential payments to the physician or physician group depend on the use of referral services. When the panel size is fewer than 25,000 enrollees' arrangements that cause substantial financial risk include, but are not limited to, the following:

1.121.1 Withholds greater than twenty-five percent (25%) of total potential payments; or

1.121.2 Withholds less than twenty-five percent (25%) of total potential payments but the physician or physician group is potentially liable for more than twenty-five percent (25%) of total potential payments; or

1.121.3 Bonuses greater than thirty-three percent (33%) of total potential payments, less the bonus; or

1.121.4 Withholds plus bonuses if the withholds plus bonuses equal more .than twenty-five percent (25%) of total potential payments; or

1.121.5 Capitation arrangements if the difference between the minimum and maximum possible payments is more than twenty-five percent (25%) of the maximum possible payments, or the minimum and maximum possible payments are not clearly explained in the Contract.

1.122 **System for Award Management (SAM)**

"System for Award Management" or "SAM" means the Official U.S. Government system that consolidated the capabilities of CCR/FedReg, ORCA and EPLS. Provider listed in the SAM should not be awarded a contract with the Contractor.

1.123 **Tracking**

"Tracking" means a record keeping system that identifies when the sender begins delivery of Confidential Information to the authorized and intended recipient, and when the sender receives confirmation of delivery from the authorized and intended recipient of Confidential Information.

1.124 **Transition of Care Document (TOC)**

"Transition of Care Document (TOC)" means a document that is supported by four key clinical document types or constructs that contain specific patient information to facilitate the exchange of information in the event of a patient care transition. The Discharge

Summary is one document type built on the Consolidated CDA (CCDA) providing demographic and summary information about the patient. The Discharge Summary is the clinical document used in the event that a patient is discharged from a healthcare provider, containing an overview of patient care information, such as demographic information, active reconciled medication list including dose and directions, allergy list, problem list, and reason for admission. The document includes both a standard dataset and a discharge context relevant dataset, both of which are determined by the discharging provider organization in accordance with local policy, regulations and law. At discharge, the summary might include content for the Discharge Instruction as well as Discharge Summary.

1.125 **Transitional Healthcare Services (THS)**

"Transitional Healthcare Services (THS)" means the mechanisms to ensure coordination and continuity of care as enrollees transfer between different locations or different levels of care within the same location. Transitional Healthcare Services are intended to prevent secondary health conditions or complications, re-institutionalization or re-hospitalization, including recidivism following substance use disorder treatment.

1.126 **Transport**

"Transport" means the movement of Confidential Information from one entity to another, or within an entity, that:

1.126.1 Places the Confidential Information outside of a Secured Area or system (such as a local area network), and

1.126.2 Is accomplished other than via a Trusted System.

1.127 **Trusted Systems**

"Trusted Systems" means methods of delivering confidential information in such a manner that confidentiality is not compromised. Trusted Systems include only the following methods of physical delivery:

1.127.1 Hand-delivery by a person authorized to have access to the Confidential Information with written acknowledgement of receipt, and

1.127.2 United States Postal Service (USPS) delivery services that include Tracking, such as Certified Mail, Express Mail or Registered Mail.

1.127.3 Any other method of physical delivery will be deemed not be a Trusted System.

1.128 **Unique User ID**

"Unique User ID" means a string of characters that identifies a specific user and which, in conjunction with a password, passphrase or other mechanism, authenticates a user to an information system.

1.129 **Validation**

"Validation" means the review of information, data, and procedures to determine the extent to which they are accurate, reliable, and free from bias and in accord with standards for data collection and analysis (42 C.F.R. § 438.320).

1.130 **Washington Administrative Code (WAC)**

"Washington Administrative Code (WAC)" means the rules adopted by agencies to implement legislation and RCWs. All references in this Contract to WAC chapters or sections shall include any successor, amended, or replacement regulation. Pertinent WAC chapters or sections can be accessed at http://www.leg.wa.gov/LawsAndAgencyRules/Pages/default.aspx

1.131 **Washington Apple Health (AH)**

"Washington Apple Health (AH)" means a title that expresses the rebranding of the Washington State Medicaid Program.

1.132 **Washington Apple Health Foster Care (AHFC)**

"Washington Apple Health Foster Care (AHFC)" means an HCA managed care program that serves foster children and children receiving adoption support services.

1.133 **Washington Healthplanfinder (HPF)**

"Washington Healthplanfinder (HPF)" means an online marketplace for individuals, families, and small businesses to compare and enroll in qualified health insurance plans.

2 GENERAL TERMS AND CONDITIONS

2.1 **Amendment**

Except as described below, an amendment to this Contract generally shall require the approval of both HCA and the Contractor. The following shall guide the amendment process:

2.1.1 Any amendment shall be in writing and shall be signed by a Contractor's authorized officer and an authorized representative of HCA. No other understandings, oral or otherwise, regarding the subject matter of this Agreement shall be deemed to exist or to bind any of the parties hereto.

2.1.2 HCA reserves the right to issue unilateral amendments which provide corrective or clarifying information.

2.1.3 The Contractor shall submit all feedback or questions to HCA at contracts@hca.wa.gov.

2.1.4 The Contractor shall submit written feedback within the expressed deadline provided to the Contractor upon receipt of any amendments. HCA is not obligated to accept Contractor feedback after the written deadline provided by HCA.

2.1.5 The Contractor shall return all signed amendments within the written deadline provided by HCA contracts administration.

2.2 Assignment

The Contractor shall not assign this Contract to a third party without the prior written consent of HCA.

2.3 Billing Limitations

2.3.1 HCA shall pay the Contractor only for services provided in accordance with this Contract.

2.3.2 HCA shall not pay any claims for payment for services submitted more than twelve (12) months after the calendar month in which the services were performed.

2.3.3 The Contractor must waive the timeliness rule for processing a claim when HCA program integrity activities result in recoupment of an improperly paid claim that HCA paid but that should have been paid by the Contractor.

2.3.3.1 The Contractor shall pay for medically necessary services submitted beyond the standard claims payment timeframes in these circumstances. If the Contractor is unable to systematically identify and waive the timeliness rules in this scenario, it is acceptable for the Contractor to address the waiver of the timeliness rule within its provider payment dispute processes.

2.3.3.2 The servicing provider must submit a claim to the Contractor within sixty (60) calendar days from HCA's notification of improper payment. The Contractor must have in place a process to administer these claims.

2.3.3.3 If the Contractor is unable to waive the timeliness rule to process an improperly paid claim identified by HCA, HCA may at any time request a refund from the Contractor of the improperly paid claim.

2.4 Compliance with Applicable Law

In the provision of services under this Contract, the Contractor and its subcontractors shall comply with all applicable federal, state and local laws and regulations, and all amendments thereto, that are in effect when the Contract is signed or that come into effect during the term of this Contract (42 C.F.R. § 438.6(f)(1) and 438.100(d)). The provisions of this Contract that are in conflict with applicable state or federal laws or regulations are hereby amended to conform to the minimum requirements of such laws or regulations. A provision of this Contract that is stricter than such laws or regulations will not be deemed a conflict. Applicable laws and regulations include, but are not limited to:

2.4.1 Title XIX and Title XXI of the Social Security Act;

2.4.2 Title VI of the Civil Rights Act of 1964;

2.4.3 Title IX of the Education Amendments of 1972, regarding any education

programs and activities;

2.4.4 The Age Discrimination Act of 1975;

2.4.5 The Rehabilitation Act of 1973;

2.4.6 The Budget Deficit Reduction Act of 2005;

2.4.7 The Washington Medicaid False Claims Act and Federal False Claims Act (FCA);

2.4.8 The Health Insurance Portability and Accountability Act (HIPAA);

2.4.9 The American Recovery and Reinvestment Act (ARRA);

2.4.10 The Patient Protection and Affordable Care Act (PPACA or ACA);

2.4.11 The Health Care and Education Reconciliation Act;

2.4.12 Chapter 70.02 RCW and the Washington State Patient Bill of Rights, including, but not limited to, the administrative and financial responsibility for independent reviews; and

2.4.13 All federal and state professional and facility licensing and accreditation requirements/standards that apply to services performed under the terms of this Contract, including but not limited to:

2.4.13.1 All applicable standards, orders, or requirements issued under Section 306 of the Clean Water Act (33 US 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40 C.F.R. Part 15), which prohibit the use of facilities included on the EPA List of Violating Facilities. Any violations shall be reported to HCA, DHHS, and the EPA.

2.4.13.2 Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, issued in compliance with the Federal Energy Policy and Conservation Act.

2.4.13.3 Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA).

2.4.13.4 Those specified in Title 18 RCW for professional licensing.

2.4.13.5 Industrial Insurance – Title 51 RCW.

2.4.13.6 Reporting of abuse as required by RCW 26.44.030.

2.4.13.7 Federal Drug and Alcohol Confidentiality Laws in 42 C.F.R. Part 2.

2.4.13.8 EEO Provisions.

2.4.13.9 Copeland Anti-Kickback Act.

2.4.13.10 Davis-Bacon Act.

2.4.13.11 Byrd Anti-Lobbying Amendment.

2.4.13.12 All federal and state nondiscrimination laws and regulations.

2.4.13.13 Americans with Disabilities Act: The Contractor shall make reasonable accommodation for enrollees with disabilities, in accord with the Americans with Disabilities Act, for all Contracted services and shall assure physical and communication barriers shall not inhibit enrollees with disabilities from obtaining contracted services.

2.4.13.14 Any other requirements associated with the receipt of federal funds.

2.5 **Confidentiality**

2.5.1 The Contractor will protect and preserve the confidentiality of HCA's data or information that is defined as confidential under state or federal law or regulation or data that HCA has identified as confidential.

2.5.2 The Contractor shall comply with all applicable federal and state laws and regulations concerning collection, use, and disclosure of Personal Information set forth in Governor Locke's Executive Order 00-03 and Protected Health Information (PHI), defined at 45 C.F.R. § 160.103, as may be amended from time to time. The Contractor shall not release, divulge, publish, transfer, sell, or otherwise make known to unauthorized third parties Personal Information or PHI without the advance express written consent of the individual who is the subject matter of the Personal Information or PHI or as otherwise required in this Contract or as permitted or required by state or federal law or regulation. The Contractor shall implement appropriate physical, electronic and managerial safeguards to prevent unauthorized access to Personal Information and PHI. The Contractor shall require the same standards of confidentiality of all its Subcontractors.

2.5.3 The Contractor agrees to share Personal Information regarding enrollees in a manner that complies with applicable state and federal law protecting confidentiality of such information (including but not limited to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, codified at 42 U.S.C. § 1320(d) et. seq. and 45 C.F.R. parts 160, 162, and 164., the HIPAA regulations, 42 C.F.R. § 431 Subpart F, 42 C.F.R. § 438.224, RCW 5.60.060(4), and Chapter 70.02 RCW). The Contractor and the Contractor's subcontractors shall fully cooperate with HCA efforts to implement HIPAA requirements.

2.5.4 The Contractor shall protect and maintain all Confidential Information gained by reason of this Contract against unauthorized use, access, disclosure, modification or loss.

2.5.4.1 This duty requires that Contractor employ reasonable security measures, which include restricting access to the Confidential Information by:

2.5.4.1.1 Encrypting electronic Confidential Information during Transport;

2.5.4.1.2 Physically Securing and Tracking media containing Confidential Information during Transport;

2.5.4.1.3 Limiting access to staff that have an authorized business requirement to view the Confidential Information;

2.5.4.1.4 Using access lists, Unique User ID and Hardened Password authentication to protect Confidential Information;

2.5.4.1.5 Physically Securing any computers, documents or other media containing the Confidential Information; and

2.5.4.1.6 Encrypting all Confidential Information that is stored on portable devices including but not limited to laptop computers and flash memory devices.

2.5.4.2 Upon request by HCA the Contractor shall return the Confidential Information or certify in writing that the Contractor employed a HCA approved method to destroy the information. Contractor may obtain information regarding approved destruction methods from the HCA contact identified in this Contract.

2.5.5 In the event of a breach, meaning an acquisition, access, use, or disclosure of PHI in a manner not permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule which compromises the security or privacy of an enrollee's PHI, the Contractor shall notify HCA in writing, as described in the Notices section of the General Terms and Conditions, within two (2) business days after determining notification must be sent to enrollees. Contractor must also take actions to mitigate the risk of loss and comply with any notification or other requirement imposed by law (45 C.F.R.Part 164, Subpart D, WAC 284-04-625, RCW 19.255.010).

2.5.6 HCA reserves the right to monitor, audit, or investigate the use of Personal Information and PHI of enrollees collected, used, or acquired by Contractor during the term of this Agreement. All HCA representatives conducting onsite audits of Contractor agree to keep confidential any patient-identifiable information which may be reviewed during the course of any site visit or audit.

2.5.7 Any material breach of this confidentiality provision may result in termination of this Contract. The Contractor shall indemnify and hold HCA harmless from any damages related to the Contractor's or Subcontractor's unauthorized use or release of Personal Information or PHI of enrollees.

2.6 **Covenant Against Contingent Fees**

The Contractor certifies that no person or selling agent has been employed or retained to solicit or secure this Contract for a commission, percentage, brokerage or contingent fee, excepting bona fide employees or bona fide established agents maintained by the Contractor for the purpose of securing business. HCA shall have the right, in the event of breach of this clause by the Contractor, to terminate this Contract or, in its discretion, to deduct from amounts due the Contractor under the Contract recover by other means the full amount of any such commission, percentage, brokerage or contingent fee.

2.7 **Debarment Certification**

The Contractor, by signature to this Contract, certifies that the Contractor is not presently debarred, suspended, proposed for debarment, declared ineligible or voluntarily excluded in any Washington State or Federal department or agency from participating in

transactions (debarred). The Contractor agrees to include the above requirement in any and all Subcontracts into which it enters, and also agrees that it will not employ debarred individuals or subcontract with any debarred providers, persons, or entities. The Contractor shall immediately notify HCA if, during the term of this Contract, the Contractor becomes debarred. HCA may immediately terminate this Contract by providing Contractor written notice in accord with Subsection 2.38 of this Contract if the Contractor becomes debarred during the term hereof.

2.8 **Defense of Legal Actions**

Each party to this Contract shall advise the other as to matters that come to its attention with respect to potential substantial legal actions involving allegations that may give rise to a claim for indemnification from the other. Each party shall fully cooperate with the other in the defense of any action arising out of matters related to this Contract by providing without additional fee all reasonably available information relating to such actions and by providing necessary testimony.

2.9 **Disputes**

When a dispute arises over an issue that pertains in any way to this Contract (other than overpayments, as described below), the parties agree to the following process to address the dispute:

2.9.1 The Contractor shall request a dispute resolution conference with the Director. The request for a dispute resolution conference must be in writing and shall clearly state all of the following:

2.9.1.1 The disputed issue(s).

2.9.1.2 An explanation of the positions of the parties.

2.9.1.3 Any additional facts necessary to explain completely and accurately the nature of the dispute.

2.9.2 Requests for a dispute resolution conference must be mailed to the Director, Washington State HCA, P.O. Box 42700, Olympia, WA 98504-2700. Any such requests must be received by the Director within fifteen (15) calendar days after the Contractor receives notice of the disputed issue(s).

2.9.2.1 The Director, in his or her sole discretion, will determine a time for the parties to present their views on the disputed issue(s). The format and time allowed for the presentations are solely within the Director's discretion. The Director will provide written notice of the time, format, and location of the conference. The conference is informal in nature and is not governed in any way by the Administrative Procedure Act, chapter 34.05 RCW.

2.9.2.2 The Director will consider all of the information provided at the conference and will issue a written decision on the disputed issue(s) within thirty (30) calendar days after the conclusion of the conference. However, the Director retains the option of taking up to an additional sixty (60) calendar days to consider the disputed issue(s) or taking additional steps to attempt to resolve them. If the Director

determines, in his or her sole discretion, that an additional period of up to sixty (60) calendar days is needed for review, he or she will notify the Contractor, in writing, of the delay and the anticipated completion date before the initial thirty-day period expires.

2.9.2.3 The Director, at his or her sole discretion, may appoint a designee to represent him or her at the dispute conference. If the Director does appoint a designee to represent him or her at the dispute conference, the Director shall retain all final decision-making authority regarding the disputed issue(s). Under no circumstances shall the Director's designee have any authority to issue a final decision on the disputed issue(s).

2.9.3 The parties hereby agree that this dispute process shall precede any judicial or quasi-judicial proceeding and is the sole administrative remedy under this Contract.

2.9.4 Disputes regarding overpayments are governed by the Notice of Overpayment Subsection of this Contract, and not by this Subsection 2.9

2.10 Force Majeure

If the Contractor is prevented from performing any of its obligations hereunder in whole or in part as a result of a major epidemic, act of God, war, civil disturbance, court order or any other cause beyond its control, such nonperformance shall not be a ground for termination for default. Immediately upon the occurrence of any such event, the Contractor shall commence to use its best efforts to provide, directly or indirectly, alternative and, to the extent practicable, comparable performance. Nothing in this Section shall be construed to prevent HCA from terminating this Contract for reasons other than for default during the period of events set forth above, or for default, if such default occurred prior to such event.

2.11 Governing Law and Venue

This Contract shall be construed and interpreted in accordance with the laws of the state of Washington and the venue of any action brought hereunder shall be in Superior Court for Thurston County. In the event that an action is removed to U.S. District Court, venue shall be in the Western District of Washington in Tacoma.

Nothing in this Contract shall be construed as a waiver by HCA of the State's immunity under the 11th Amendment to the United States Constitution.

2.12 Independent Contractor

The parties intend that an independent Contractor relationship will be created by this Contract. The Contractor and its employees or agents performing under this Contract are not employees or agents of the HCA or the State of Washington. The Contractor, its employees, or agents performing under this Contract will not hold himself/herself out as, nor claim to be, an officer or employee of the HCA or the State of Washington by reason hereof, nor will the Contractor, its employees, or agent make any claim of right, privilege or benefit that would accrue to such employee. The Contractor acknowledges and certifies

that neither HCA nor the State of Washington are guarantors of any obligations or debts of the Contractor.

2.13 Insolvency

If the Contractor becomes insolvent during the term of this Contract:

2.13.1 The State of Washington and enrollees shall not be, in any manner, liable for the debts and obligations of the Contractor (42 C.F.R. § 438.106(a) and 438.116(a)(1)).

2.13.2 In accord with the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract under no circumstances shall the Contractor, or any providers used to deliver services covered under the terms of this Contract, charge enrollees for Contracted services (42 C.F.R. § 438.106(b)(1)).

2.13.3 The Contractor shall, in accord with RCW 48.44.055 or 48.46.245, provide for the continuity of care for enrollees.

2.13.4 The Contractor shall cover continuation of services to enrollees for duration of period for which payment has been made, as well as for inpatient admissions up until discharge.

2.14 Inspection

The Contractor and its subcontractors shall cooperate with all audits and investigations performed by duly authorized representatives of the State of Washington, including HCA and MFCU, as well as the federal Department of Health and Human Services, auditors from the federal Government Accountability Office, federal Office of the Inspector General and federal Office of Management and Budget. The Contractor and its subcontractors shall provide access to their facilities and the records documenting the performance of this Contract, for purpose of audits, investigations, and for the identification and recovery of overpayments within thirty (30) calendar days, and access to its facilities and the records pertinent to this Contract to monitor and evaluate performance under this Contract, including, but not limited to, claims payment and the quality, cost, use, health and safety and timeliness of services, provider network adequacy, including panel capacity or willingness to accept new patients, and assessment of the Contractor's capacity to bear the potential financial losses. The Contractor and its subcontractors shall provide immediate access to facilities and records pertinent to this Contract for State or Federal fraud investigators (42 C.F.R. § 438.6(g)).

2.15 Insurance

The Contractor shall at all times comply with the following insurance requirements:

2.15.1 Commercial General Liability Insurance (CGL): The Contractor shall maintain CGL insurance, including coverage for bodily injury, property damage, and contractual liability, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000. The policy shall include liability arising out of premises, operations, independent Contractors, products-completed operations, personal injury, advertising injury, and liability assumed

under an insured Contract. The State of Washington, HCA, its elected and appointed officials, agents, and employees shall be named as additional insured's expressly for, and limited to, Contractor's services provided under this Contract.

2.15.2 Professional Liability Insurance (PL): The Contractor shall maintain Professional Liability Insurance, including coverage for losses caused by errors and omissions, with the following minimum limits: Each Occurrence - $1,000,000; General Aggregate - $2,000,000.

2.15.3 Worker's Compensation: The Contractor shall comply with all applicable worker's compensation, occupational disease, and occupational health and safety laws and regulations. The State of Washington and HCA shall not be held responsible as an employer for claims filed by the Contractor or its employees under such laws and regulations.

2.15.4 Employees and Volunteers: Insurance required of the Contractor under the Contract shall include coverage for the acts and omissions of the Contractor's employees and volunteers.

2.15.5 Subcontractors: The Contractor shall ensure that all subcontractors have and maintain insurance appropriate to the services to be performed. The Contractor shall make available copies of Certificates of Insurance for subcontractors, to HCA if requested.

2.15.6 Separation of Insured's: All insurance Commercial General Liability policies shall contain a "separation of insured's" provision.

2.15.7 Insurers: The Contractor shall obtain insurance from insurance companies authorized to do business within the State of Washington, with a "Best's Reports'' rating of A-, Class VII or better. Any exception must be approved by HCA. Exceptions include placement with a "Surplus Lines" insurer or an insurer with a rating lower than A-, Class VII.

2.15.8 Evidence of Coverage: The Contractor shall submit Certificates of Insurance in accord with the Notices section of the General Terms and Conditions, for each coverage required under this Contract upon execution of this Contract. Each Certificate of Insurance shall be executed by a duly authorized representative of each insurer.

2.15.9 Material Changes: The Contractor shall give HCA, in accord with the Notices section of the General Terms and Conditions, forty-five (45) calendar days advance notice of cancellation or non-renewal of any insurance in the Certificate of Coverage. If cancellation is due to non-payment of premium, the Contractor shall give HCA ten (10) calendar days advance notice of cancellation.

2.15.10 General: By requiring insurance, the State of Washington and HCA do not represent that the coverage and limits specified will be adequate to protect the Contractor. Such coverage and limits shall not be construed to relieve the Contractor from liability in excess of the required coverage and limits and shall not limit the Contractor's liability under the indemnities and reimbursements granted to the State and HCA in this Contract. All insurance provided in compliance with this Contract shall be primary as to any other insurance or self-

insurance programs afforded to or maintained by the State.

2.15.11 The Contractor may waive the requirements as described in the Commercial General Liability Insurance, Professional Liability Insurance, Insurers and Evidence of Coverage provisions of this Section if self-insured. In the event the Contractor is self-insured, the Contractor must send to HCA by the third Wednesday of January in each Contract year, a signed written document, which certifies that the Contractor is self-insured, carries coverage adequate to meet the requirements of this Section, will treat HCA as an additional insured, expressly for, and limited to, the Contractor's services provided under this Contract, and provides a point of contact for HCA.

2.16 Records

2.16.1 The Contractor and its subcontractors shall maintain all financial, medical and other records pertinent to this Contract. All financial records shall follow generally accepted accounting principles. Other records shall be maintained as necessary to clearly reflect all actions taken by the Contractor related to this Contract.

2.16.2 All records and reports relating to this Contract shall be retained by the Contractor and its subcontractors for a minimum of six (6) years after final payment is made under this Contract. However, when an audit, litigation, or other action involving records is initiated prior to the end of said period, records shall be maintained for a minimum of six (6) years following resolution of such action (RCW 40.14.060).

2.16.3 The Contractor acknowledges the HCA is subject to the Public Records Act (Chapter 42.56 RCW). This Contract will be a “public record” as defined in Chapter 42.56 RCW. Any documents submitted to HCA by the Contractor may also be construed as “public records” and therefore subject to public disclosure under chapter 42.56 RCW.

2.17 Mergers and Acquisitions

If the Contractor is involved in an acquisition of assets or merger with another HCA Contractor after the effective date of this Contract, HCA reserves the right, to the extent permitted by law, to require that each Contractor maintain its separate business lines for the remainder of the Contract period. The Contractor does not have an automatic right to a continuation of the Contract after any such acquisition of assets or merger.

2.18 Notification of Organizational Changes

The Contractor shall provide HCA with ninety (90) calendar days’ prior written notice of any change in the Contractor’s ownership or legal status. The Contractor shall provide HCA notice of any changes to the Contractor’s key personnel including, but not limited to, the Contractor’s Chief Executive Officer, the Contractor’s Chief Financial Officer, HCA government relations contact, HCA Account Executive, and Medical Director as soon as reasonably possible.

2.19 **Order of Precedence**

In the interpretation of this Contract and incorporated documents, the various terms and conditions shall be construed as much as possible to be complementary. In the event that such interpretation is not possible the following order of precedence shall apply:

2.19.1 Federal statutes and regulations applicable to the services provided under this Contract.

2.19.2 State of Washington statutes and regulations concerning the operation of HCA programs participating in this Contract.

2.19.3 Applicable State of Washington statutes and regulations concerning the operation of Health Maintenance Organizations, Health Care Service Contractors, and Life and Disability Insurance Carriers.

2.19.4 General Terms and Conditions of this Contract.

2.19.5 Any other term and condition of this Contract and exhibits.

2.19.6 Any other material incorporated herein by reference.

2.20 **Severability**

If any term or condition of this Contract is held invalid by any court of competent jurisdiction, and if all appeals have been exhausted, such invalidity shall not affect the validity of the other terms or conditions of this Contract.

2.21 **Survivability**

The terms and conditions contained in this Contract that shall survive the expiration or termination of this Contract include but are not limited to: Confidentiality, Fraud, Overpayment, Indemnification and Hold Harmless, Inspection and Maintenance of Records. After termination of this Contract, the Contractor remains obligated to:

2.21.1 Cover hospitalized enrollees until discharge consistent with this Contract.

2.21.2 Submit reports required in this Contract.

2.21.3 Provide access to records required in accord with the Inspection provisions of this Section.

2.21.4 Provide the administrative services associated with Contracted services (e.g. claims processing, enrollee appeals) provided to enrollees prior to the effective date of termination under the terms of this Contract.

2.21.5 Repay any overpayments that:

2.21.5.1 Pertain to services provided at any time during the term of this Contract; and

2.21.5.2 Are identified through an HCA audit or other HCA administrative review at any time on or before six (6) years from the date of the termination of this Contract; or

2.21.5.3 Are identified through a fraud investigation conducted by the Medicaid

Fraud Control Unit or other law enforcement entity, based on the timeframes provided by federal or state law.

2.21.6 Reimburse providers for claims erroneously billed to and paid by HCA within the twenty-four months before the expiration or termination of this Contract.

2.22 Waiver

Waiver of any breach or default on any occasion shall not be deemed to be a waiver of any subsequent breach or default. Any waiver shall not be construed to be a modification of the terms and conditions of this Contract. Only the Director of the HCA or his or her designee has the authority to waive any term or condition of this Contract on behalf of HCA.

2.23 Contractor Certification Regarding Ethics

The Contractor certifies that the Contractor is now, and shall remain, in compliance with Chapter 42.52 RCW, Ethics in Public Service, throughout the term of this Contract.

2.24 Health and Safety

Contractor shall perform any and all of its obligations under this Contract in a manner that does not compromise the health and safety of any HCA client with whom the Contractor has contact. The Contractor shall require participating hospitals, ambulatory care surgery centers, and office-based surgery sites to endorse and adopt procedures for verifying the correct patient, the correct procedure, and the correct surgical site that meets or exceeds those set forth in the Universal Protocol™ developed by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other similar standards.

2.25 Indemnification and Hold Harmless

HCA and the Contractor shall each be responsible for their own acts and omissions, and the acts and omissions of their agents and employees. Each party to this Contract shall defend, protect and hold harmless the other party, or any of the other party's agents, from and against any loss and all claims, settlements, judgments, costs, penalties, and expenses, including attorney fees, arising from any willful misconduct, or dishonest, fraudulent, reckless, unlawful, or negligent act or omission of the first party, or agents of the first party, while performing under the terms of this Contract except to the extent that such losses result from the willful misconduct, or dishonest, fraudulent, reckless, unlawful or negligent act or omission on the part of the second party. The Contractor shall indemnify and hold harmless HCA from any claims by Participating or non-Participating Providers related to the provision of services to Enrollees according to the terms of this Contract. Each party agrees to promptly notify the other party in writing of any claim and provide the other party the opportunity to defend and settle the claim. The Contractor waives its immunity under Title 51 RCW to the extent it is required to indemnify, defend, and hold harmless the State and its agencies, officials, agents, or employees.

2.26 Industrial Insurance Coverage

The Contractor shall comply with the provisions of Title 51 RCW, Industrial Insurance. If the Contractor fails to provide industrial insurance coverage or fails to pay premiums or

penalties on behalf of its employees, as may be required by law, HCA may collect from the Contractor the full amount payable to the Industrial Insurance accident fund. HCA may deduct the amount owed by the Contractor to the accident fund from the amount payable to the Contractor by HCA under this Contract, and transmit the deducted amount to the Department of Labor and Industries, (L&I) Division of Insurance Services. This provision does not waive any of L&I's rights to collect from the Contractor.

2.27 **No Federal or State Endorsement**

The award of this Contract does not indicate an endorsement of the Contractor by the Centers for Medicare and Medicaid Services (CMS), the federal government, or the State of Washington. No federal funds have been used for lobbying purposes in connection with this Contract or managed care program.

2.28 **Notices**

Whenever one party is required to give notice to the other under this Contract, it shall be deemed given if mailed by United States Postal Services, registered or certified mail, return receipt requested, postage prepaid and addressed as follows:

2.28.1 In the case of notice to the Contractor, notice will be sent to:

«CEO»
«Organization_Name»
«Mailing_AddressSt_Address»
«City», «State» «Zip_Code»

2.28.2 In the case of notice to HCA, send notice to:

Contract Administrator
HCA
Legal and Administrative Services
Contracts Office
P.O. Box 42702
Olympia, WA 98504-2702

2.28.3 Notices shall be effective on the date delivered as evidenced by the return receipt or the date returned to the sender for non-delivery other than for insufficient postage.

2.28.4 Either party may at any time change its address for notification purposes by mailing a notice in accord with this Section, stating the change and setting for the new address, which shall be effective on the tenth (10th) day following the effective date of such notice unless a later date is specified.

2.29 **Notice of Overpayment**

2.29.1 If HCA determines it has made an overpayment to the Contractor, then HCA will issue a Notice of Overpayment to the Contractor.

2.29.2 The Contractor may contest a Notice of Overpayment by requesting an adjudicative proceeding. The request for an adjudicative proceeding must:

2.29.2.1 Comply with all of the instructions contained in the Notice of Overpayment;

2.29.2.2 Be received by HCA within twenty-eight (28) calendar days of service receipt of the Notice of Overpayment by the Contractor;

2.29.2.3 Be sent to HCA by certified mail (return receipt), to the location specified in the Notice of Overpayment;

2.29.2.4 Include a statement and supporting documentation as to why the Contractor thinks the Notice of Overpayment is incorrect; and

2.29.2.5 Include a copy of the Notice of Overpayment.

2.29.3 If the Contractor submits a timely and complete request for an adjudicative proceeding, then the Office of Administrative Hearings will schedule the proceeding. The Contractor may be offered a pre-hearing or alternative dispute resolution conference in an attempt to resolve the dispute prior to the adjudicative proceeding. The adjudicative proceeding will be governed by the administrative procedure act, chapter 34.05 RCW, and chapter 182-526 WAC.

2.29.4 If HCA does not receive a request for an adjudicative proceeding within twenty-eight (28) calendar days of service of a Notice of Overpayment, then the Contractor will be responsible for repaying the amount specified in the Notice of Overpayment. This amount will be considered a final debt to HCA from the Contractor. HCA may charge the Contractor interest and any costs associated with the collection of the debt. HCA may collect an overpayment debt through lien, foreclosure, seizure and sale of the Contractor's real or personal property; order to withhold and deliver; withholding the amount of the debt from any future payment to the Contractor under this contract; or any other collection action available to HCA to satisfy the overpayment debt.

2.29.5 Nothing in this Agreement limits HCA's ability to recover overpayments under applicable law.

2.30 **Proprietary Data or Trade Secrets**

2.30.1 Except as required by law, regulation, or court order, data identified by the Contractor as proprietary trade secret information shall be kept strictly confidential, unless the Contractor provides prior written consent of disclosure to specific parties. Any release or disclosure of data shall include the Contractor's interpretation.

2.30.2 The Contractor shall identify data which it asserts is proprietary or is trade secret information as permitted by RCW 41.05.026. If HCA anticipates releasing data that is identified as proprietary or trade secrets, HCA will notify the Contractor upon receipt of any request under the Public Records Act (chapter 42.56 RCW) or otherwise for data or Claims Data identified by the Contractor as proprietary trade secret information and will not release any such information until five (5) business days after it has notified the Contractor of the receipt of such request. If the Contractor files legal proceedings within the aforementioned five (5)

business day period in an attempt to prevent disclosure of the data, HCA agrees not to disclose the information unless it is ordered to do so by a court, the Contractor dismisses its lawsuit, or the Contractor agrees that the data may be released.

2.30.3 Nothing in this Section shall prevent HCA from filing its own lawsuit or joining any other lawsuit in an attempt to prevent disclosure of the data, or to obtain a declaration as to the disclosure of the data, provided that HCA will promptly notify the Contractor of the filing of any such lawsuit.

2.31 Ownership of Material

HCA recognizes that nothing in this Contract shall give HCA ownership rights to the systems developed or acquired by the Contractor during the performance of this Contract. The Contractor recognizes that nothing in this Contract shall give the Contractor ownership rights to the systems developed or acquired by HCA during the performance of this Contract.

2.32 Solvency

2.32.1 The Contractor shall have a Certificate of Registration as a Health Maintenance Organization (HMO), Health Care Service Contractor (HCSC) or Life and Disability Insurance Carrier, from the Washington State Office of the Insurance Commissioner (OIC). The Contractor shall comply with the solvency provisions of chapters 48.21, 48.21a, 48.44 or 48.46 RCW, as amended.

2.32.2 The Contractor agrees that HCA may at any time access any information related to the Contractor's financial condition, or compliance with the Office of the Insurance Commissioner (OIC) requirements, from OIC and consult with OIC concerning such information.

2.32.3 The Contractor shall deliver to HCA copies of any financial reports prepared at the request of the OIC. The Contractor's routine quarterly and annual statements submitted to the OIC are exempt from this requirement. The Contractor shall also deliver copies of related documents and correspondence (including, but not limited to, Risk-Based Capital [RBC] calculations and Management's Discussion and Analysis), at the same time the Contractor submits them to the OIC.

2.32.4 The Contractor shall notify HCA within ten (10) business days after the end of any month in which the Contractor's net worth (capital and/or surplus) reaches a level representing two or fewer months of expected claims and other operating expenses, or other change which may jeopardize its ability to perform under this Contract or which may otherwise materially affect the relationship of the parties under this Contract.

2.32.5 The Contractor shall notify HCA within 24 hours after any action by the OIC which may affect the relationship of the parties under this Contract.

2.32.6 The Contractor shall notify HCA if the OIC requires enhanced reporting requirements within fourteen (14) calendar days after the Contractor's notification by the OIC. The Contractor agrees that HCA may, at any time, access any financial reports submitted to the OIC in accordance with any enhanced reporting

requirements and consult with OIC staff concerning information contained therein.

2.33 **Conflict of Interest Safeguards**

The Contractor shall have conflict of interest safeguards that, at a minimum, are equivalent to conflict of interest safeguards imposed by federal law on parties involved in public Contracting (41 U.S.C. § 423).

2.34 **Reservation of Rights and Remedies**

A material default or breach in this Contract will cause irreparable injury to HCA. In the event of any claim for default or breach of this Contract, no provision in this Contract shall be construed, expressly or by implication, as a waiver by the State of Washington to any existing or future right or remedy available by law. Failure of the state of Washington to insist upon the strict performance of any term or condition of this Contract or to exercise or delay the exercise of any right or remedy provided in this Contract or by law, or the acceptance of (or payment for) materials, equipment or services, shall not release Contractor from any responsibilities or obligations imposed by this Contract or by law, and shall not be deemed a waiver of any right of the state of Washington to insist upon the strict performance of this Contract. In addition to any other remedies that may be available for default or breach of this Contract, in equity or otherwise, HCA may seek injunctive relief against any threatened or actual breach of this Contract without the necessity of proving actual damages. HCA reserves the right to recover any or all administrative costs incurred in the performance of this Contract during or as a result of any threatened or actual breach.

2.35 **Termination by Default**

2.35.1 **Termination by Contractor**. The Contractor may terminate this Contract whenever HCA defaults in performance of the Contract and fails to cure the default within a period of one hundred twenty (120) calendar days (or such longer period as the Contractor may allow) after receipt from the Contractor of a written notice, as described in the Notices section of the General Terms and Conditions, specifying the default. For purposes of this Section, “default” means failure of HCA to meet one or more material obligations of this Contract. In the event it is determined that HCA was not in default, HCA may claim damages for wrongful termination through the dispute resolution provisions of this Contract or by a court of competent jurisdiction.

2.35.2 **Termination by HCA**. HCA may terminate this Contract if HCA determines:

2.35.2.1 The Contractor did not fully and accurately make any disclosure required under 42 C.F.R. 455.116(a).

2.35.2.2 The Contractor failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(d)).

2.35.2.3 One of the Contractor’s owners failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R.

455.416(d)).

2.35.2.4 The Contractor's agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of the Contractor, failed to timely submit accurate information required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(d)).

2.35.2.5 One of the Contractor's owners did not cooperate with any screening methods required under 42 C.F.R. 455, Subpart E. (42 C.F.R. 455.416(a)).

2.35.2.6 One of the Contractor's owners has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years. (42 C.F.R. 455.416(b)).

2.35.2.7 The Contractor has been terminated under title XVIII of the Social Security Act, or under any states' Medicaid or CHIP program. (42 C.F.R. 455.416(c)).

2.35.2.8 One of the Contractor's owners fails to submit sets of fingerprints in a form and manner to be determined by HCA within 30 days of a CMS or HCA request. (42 C.F.R. 455.416(e); 42 C.F.R. 455.450(d)).

2.35.2.9 The Contractor failed to permit access to one of the Contractor's locations for site visits under 42 C.F.R. 455.432. (42 C.F.R. 455.416(f)).

2.35.2.10 The Contractor has falsified any information provided on its application. (42 C.F.R. 455.416(g)).

2.36 **Termination for Convenience**

Notwithstanding any other provision of this Contract, the HCA may, by giving thirty (30) calendar days written notice, beginning on the second day after the mailing, terminate this Contract in whole or in part when it is in the best interest of HCA, as determined by HCA in its sole discretion. If this Contract is so terminated, HCA shall be liable only for payment in accordance with the terms of this contract for services rendered prior to the effective date of termination.

2.37 **Termination due to Federal Impact**

Notwithstanding any provision in this Contract to the contrary, if HCA does not receive Centers for Medicare and Medicaid Services (CMS) approval of this Contract, HCA shall provide at least thirty (30) calendar days' prior written notice of termination of this Contract to the Contractor. The effective date of any such termination hereunder shall be the earliest date that is at least thirty (30) calendar days following the date the notice is sent and occurs on the last day of a calendar month. HCA shall not be relieved of its obligation

under this Contract, including payment to the Contractor, for the period from the Contract Effective Date through the effective date of termination.

2.38 **Terminations: Pre-termination Processes**

Either party to the Contract shall give the other party to the Contract written notice, as described in the Notices section of the General Terms and Conditions of this Contract, of the intent to terminate this Contract and the reason for termination.

HCA shall provide written notice to the Contractor's enrollees of the decision to terminate the Contract and indicate whether the Contractor may appeal the decision.

2.38.1 If either party disagrees with the other party's decision to terminate this Contract, that party will have the right to a dispute resolution as described in the Disputes section of this Contract.

2.38.2 If the Contractor disagrees with a HCA decision to terminate this Contract and the dispute process is not successful, HCA shall provide the Contractor a pre-termination hearing prior to termination of the Contract under 42 C.F.R. § 438.708. HCA shall:

2.38.2.1 Give the Contractor written notice of the intent to terminate, the reason for termination, and the time and place of the hearing;

2.38.2.2 Give the Contractor (after the hearing) written notice of the decision affirming or reversing the proposed termination of this Contract, and for an affirming decision the effective date of termination; and

2.38.2.3 For an affirming decision, give enrollees notice of the termination and information consistent with 42 C.F.R. § 438.10 on their options for receiving Medicaid services following the effective date of termination.

2.39 **Savings**

In the event funding from any state, federal, or other sources is withdrawn, reduced, or limited in any way after the date this Contract is signed and prior to the termination date, HCA may, in whole or in part, suspend or terminate this Contract upon fifteen (15) calendar days' prior written notice to Contractor or upon the effective date of withdrawn or reduced funding, whichever occurs earlier. At HCA's sole discretion the Contract may be renegotiated under the revised funding conditions. If this Contract is so terminated or suspended, HCA shall be liable only for payment in accordance with the terms of this Contract for services rendered prior to the effective date.

2.40 **Post Termination Responsibilities**

The following requirements survive termination of this Contract. Contractor shall:

2.40.1 Cover Enrollees hospitalized on the date of termination until discharge, consistent with the terms of this Contract;

2.40.2 Submit all data and reports required in the Contract;

2.40.3 Provide access to records, related to audits and performance reviews; and

2.40.4 Provide administrative services associated with services (e.g., claims processing and Enrollee appeals) to be provided to Enrollees under the terms of this Contract.

2.41 Termination - Information on Outstanding Claims

In the event this Contract is terminated, the Contractor shall provide HCA, within three hundred and sixty-five (365) calendar days, all available information reasonably necessary for the reimbursement of any outstanding claims for services to enrollees (42 C.F.R. § 434.6(a)(6)). Information and reimbursement of such claims is subject to the provisions of the Payment and Sanctions Section of this Contract.

2.42 Treatment of Client Property

Unless otherwise provided, the Contractor shall ensure that any adult client receiving services from the Contractor has unrestricted access to the client's personal property. The Contractor shall not interfere with any adult client's ownership, possession, or use of the client's property. The Contractor shall provide clients under age eighteen (18) with reasonable access to their personal property that is appropriate to the client's age, development, and needs. Upon termination of the Contract, the Contractor shall immediately release to the client and/or the client's guardian or custodian all of the client's personal property.

2.43 Administrative Simplification

The Contractor shall comply with the requirements of RCW 70.14.155 and Chapter 48.165 RCW.

2.43.1 To maximize understanding, communication, and administrative economy among all managed care Contractors, their Subcontractors, governmental entities, and Enrollees, Contractor shall use and follow the most recent updated versions of:

- Current Procedural Terminology (CPT)
- International Classification of Diseases (ICD)
- Healthcare Common Procedure Coding System (HCPCS)
- CMS Relative Value Units (RVUs)
- CMS billing instructions and rules
- NCPDP Telecommunication Standard D.O.
- Medi-Span® Master Drug Data Base or other nationally recognized drug data base with approval by HCA.

2.43.2 The Contractor must follow National Correct Coding Initiative (NCCI) policies to control improper coding that leads to inappropriate payments. The Contractor must incorporate compatible NCCI methodologies in its payment systems for processing Medicaid claims. The NCCI editing should occur in addition to current procedure code review and editing by the Contractor's claims payment systems.

2.43.3 In lieu of the most recent versions, Contractor may request an exception. HCA's

consent thereto will not be unreasonably withheld.

2.43.4 Contractor may set its own conversion factor(s), including special code-specific or group-specific conversion factors, as it deems appropriate.

3 MARKETING AND INFORMATION REQUIREMENTS

3.1 Marketing

3.1.1 All marketing materials must be reviewed by and have written approval of HCA prior to distribution (42 C.F.R. § 438.104(b)(1)(i)). Marketing materials must be developed and submitted in accordance with the Marketing Guidelines developed and distributed by the HCA. Marketing materials include any items developed by the Contractor for distribution to enrollees or potential enrollees that are intended to provide information about the Contractor's benefit administration, including:

3.1.1.1 Print media;

3.1.1.2 Websites; and

3.1.1.3 Electronic Media (Television/Radio/Internet)/Social Media.

3.1.2 Marketing materials shall not contain misrepresentations, or false, inaccurate or misleading information (42 C.F.R. § 438.104(b)(2)).

3.1.3 Marketing materials must be distributed in all service areas the Contractor serves (42 C.F.R. § 438.104(b)(1)(ii)).

3.1.4 Marketing materials must be in compliance with the Equal Access for Enrollees and Potential Enrollees with Communication Barriers provisions of this Section.

3.1.4.1 Marketing materials in English must give directions for obtaining understandable materials in the population's primary languages, as identified by HCA.

3.1.4.2 HCA may determine, in its sole judgment, if materials that are primarily visual, auditory, or tactile meet the requirements of this Contract.

3.1.5 The Contractor shall not offer or accept (other than the payment by HCA) anything of value as an inducement to enrollment.

3.1.6 The Contractor shall not offer the sale of other insurance to attempt to influence enrollment (42 C.F.R. § 438.104(b)(1)(iv)).

3.1.7 The Contractor shall not directly or indirectly conduct door-to-door, telephonic or other cold-call marketing of enrollment (42 C.F.R. § 438.104(b)(1)(v)).

3.1.8 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that a potential enrollee must enroll with the Contractor in order to obtain benefits or in order not to lose benefits (42 C.F.R. § 438.104(b)(2)(i)).

3.1.9 The Contractor shall not make any assertion or statement, whether written or oral, in marketing materials that the Contractor is endorsed by CMS, the Federal or State government or similar entity (42 C.F.R. § 438.104(b)(2)(ii)).

3.1.10 The Contractor may participate in community events, including health fairs, educational events, and booths at other community events. The Contractor shall submit to HCA a quarterly report, listing all AH events in which the Contractor has participated in the previous quarter. Quarterly reports are due on the 15th of January, April, July and October.

3.2 Information Requirements for Enrollees and Potential Enrollees

3.2.1 The Contractor shall provide to potential enrollees and new enrollees the information needed to understand benefit coverage and obtain care in accord with the provisions of this Section (42 C.F.R. § 438.10(b)(3) and 438.10(f)(3)). The information shall be provided at least once a year, or upon request and within fifteen (15) working days of enrollment.

The Contractor shall notify enrollees of their ability to request the information at any time. If the enrollee or potential enrollee is not able to understand written information, the Contractor will provide at no cost the necessary information in an alternative format that is understandable to the enrollee or potential enrollee.

3.2.2 The HCA will produce a managed care handbook template for use by the Contractor. The HCA-produced template and HCA-approved Contractor handbook will provide sufficient, accurate written information to assist potential enrollees in making an informed decision about enrollment in accord with the provisions of this Section (SSA 1932(d)(2) and 42 C.F.R. § 438.10 and 438.104(b)(1)(iii)). The Contractor shall produce the managed care handbook according to the following schedule:

3.2.2.1 HCA shall provide the Contractor a pre-approved, managed care handbook template for production of a managed care handbook by September 1, 2015.

3.2.2.2 The Contractor shall complete an MCO-specific managed care handbook using the template and submit to HCA in MS Word format by September 30, 2015.

3.2.2.3 The HCA shall review and approve the Contractor's MCO-specific managed care handbook no later than October 24, 2015.

3.2.2.4 Once approved, the Contractor shall be responsible for production, translation, printing and mailing costs of the HCA-approved managed care handbook.

3.2.2.5 The Contractor's handbook shall go into production for January 1, 2016 enrollment.

3.2.2.6 The Contractor shall provide to each enrollee and to each potential enrollee who requests it, the HCA-approved managed care handbook.

3.2.2.7 The Contractor shall ensure the HCA-approved managed care handbook is translated or provided in an alternative format that is

understandable to the potential enrollee.

3.2.2.8 The Contractor shall develop content for the managed care handbook in the sections labeled for Contractor use in the template.

3.2.2.9 The Contractor may develop supplemental materials in addition to the managed care handbook that is sent to newly enrolled and assigned enrollees. This supplemental, plan-specific material shall be incorporated into the managed care handbook template as instructed by HCA, and does not include mandatory materials such as NCQA-required materials and the annual notices that the Contractor is required to send to enrollees.

3.2.2.10 Supplemental materials may not duplicate information, such as covered benefits, contained in the HCA's approved handbook template and the Contractor's approved managed care handbook, but may include contact numbers for Contractor's customer service, information about the Contractor's authorization processes, network providers and/or Value Added Benefits that the Contractor may provide.

3.2.2.11 If the enrollee is not able to understand written information provided by the Contractor, the Contractor shall provide the necessary information in an alternative format that is understandable to the enrollee.

3.2.2.12 The Contractor shall submit branding materials developed by the Contractor that specifically mention Medicaid, AH or the specific benefits provided under this Contract for review and approval. No such materials shall be disseminated to enrollees, potential enrollees, providers or other members of the public without HCA's approval.

3.2.3 The Contractor shall submit enrollee information developed by the Contractor that specifically mentions AH or the specific benefits provided under this Contract at least thirty (30) calendar days prior to distribution for review and approval. All other enrollee materials shall be submitted as informational. HCA may waive the thirty day requirement if, in HCA's sole judgment, it is in the best interest of HCA and its clients to do so.

3.2.4 The Contractor shall notify all new Health Home-eligible enrollees of their eligibility for the Health Home program. The notice shall include all of the following:

3.2.4.1 A description of the benefits of the program:

3.2.4.2 Confirmation that program participation is voluntary and not a condition for the enrollee's receipt of any other covered service;

3.2.4.3 Information about how to file grievances and appeals;

3.2.4.4 A statement that a participant has the right to change care coordination providers and the procedure for doing so; and

3.2.4.5 How to obtain more information about the program.

3.2.5 The Contractor shall notify all known pregnant enrollees about their eligibility to participate and receive Maternity Support Services (MSS) through the HCA First Steps program.

3.2.5.1 The Contractor must use the HCA MSS informational letter template to notify these clients. HCA will provide the template to the Contractor. No later than the twentieth each month, the Contractor shall submit to HCA a list of all enrollees who are newly identified within the preceding month as pregnant or are within sixty (60) days postpartum. The Contractor shall submit the list to HCA at hcamcprograms@hcawa.gov using the HCA First Steps Maternity Support Services report template. HCA will provide the Support Services report template to the Contractor.

3.2.6 Changes to State or Federal law shall be reflected in information to enrollees no more than ninety (90) calendar days after the effective date of the change and enrollees shall be notified at least thirty (30) calendar days prior to the effective date if, in the sole judgment of HCA, the change is significant in regard to the enrollees' quality of or access to care, which may include changes to: enrollment rights, grievance and hearing procedures, benefits, authorizations or coverage of emergency services. HCA shall notify the Contractor in writing of any significant change (42 C.F.R. § 438.6(i)(4) and 438.10(f)(4)).

3.2.7 The Contractor shall use an HCA approved managed care handbook for enrollees and potential enrollees that provides written information about:

3.2.7.1 Choosing a PCP, including general information on available PCPs and how to obtain specific information including a list of PCPs that includes their identity, location, languages spoken, qualifications, practice restrictions, and availability.

3.2.7.2 How to change PCPs.

3.2.7.3 How to access services outside the Contractor's service area.

3.2.7.4 How to access Emergency, after hours and urgent services.

3.2.7.5 How to access hospital care and how to get a list of hospitals that are available to enrollees.

3.2.7.6 How to access mental health and chemical dependency providers.

3.2.7.7 Specialists available to enrollees, including mental health and chemical dependency providers and how to obtain specific information including a list of specialists, their identity, location, languages spoken, qualifications, practice restrictions and availability.

3.2.7.8 Pharmacies available to enrollees and how to obtain specific information including a list of pharmacies that includes their identity, location, and hours of operation.

3.2.7.9 Limitations to the availability of or referral to specialists and assistance offered to the enrollee in selecting a PCP, including any medical group restrictions.

3.2.7.10 How to get direct access to a Woman's Healthcare specialist within the Contractor's network.

3.2.7.11 How to get information about Physician Incentive Plans (42 C.F.R. § 422.208 and 422.210).

3.2.7.12 How to get information on the Contractor's structure and operations (42 C.F.R. § 438.10(g)).

3.2.7.13 Informed consent guidelines.

3.2.7.14 Conversion rights under RCW 48.46.450 or RCW 48.44.370.

3.2.7.15 How to request a termination of enrollment.

3.2.7.16 Information regarding advance directives and POLSTs to include (42 C.F.R. § 422.128 and 438.6(i)(1 and 3)):

3.2.7.16.1 A statement about an enrollee's right to make decisions concerning an enrollee's medical care, accept or refuse surgical or medical treatment, execute an advance directive, and revoke an advance directive at any time.

3.2.7.16.2 The Contractor's written policies and procedures concerning advance directives, including any policy that would preclude the Contractor or subcontractor from honoring an enrollee's advance directive or POLST.

3.2.7.16.3 An enrollee's rights under state law, including the right to file a grievance with the Contractor or HCA regarding compliance with advance directive requirements in accord with the Advance Directive and POLST provisions of the Enrollee Rights and Protections Section of this Contract.

3.2.7.17 How to recommend changes in the Contractor's policies and procedures.

3.2.7.18 What health promotion, health education and preventive health services are available.

3.2.7.19 Information on the Contractor's Grievance System including (42 C.F.R. § 438.10(f)(2), 438.10(f)(6)(iv), 438.10(g)(1) and SMM2900 and 2902.2):

3.2.7.19.1 How to obtain assistance from the Contractor in using the grievance, appeal and independent review processes (must assure enrollees that information will be kept confidential

except as needed to process the grievance, appeal or independent review).

3.2.7.19.2 The enrollees' right to and how to initiate a grievance or file an appeal, in accord with the Contractor's HCA approved policies and procedures regarding grievances and appeals.

3.2.7.19.3 The enrollees' right to and how to request a hearing after the Contractor's appeal process is exhausted, how to request a hearing and the rules that govern representation at the hearing.

3.2.7.19.4 The enrollees' right to and how to request an independent review in accord with RCW 48.43.535 and Chapters 246-305 and 284-43 WAC after the hearing process is exhausted and how to request an independent review.

3.2.7.19.5 The enrollees' right to appeal to the Board of Appeals and how to request such an appeal.

3.2.7.19.6 The requirements and timelines for grievances, appeals, hearings, independent review and Board of Appeals.

3.2.7.19.7 The enrollees' rights and responsibilities, including potential payment liability, regarding the continuation of services that are the subject of appeal or a hearing.

3.2.7.19.8 The availability of toll-free numbers for information about grievances and appeals and to file a grievance or appeal.

3.2.7.20 The enrollee's rights and responsibilities with respect to accessing contracted services.

3.2.7.21 Information about covered benefits and how to contact HCA regarding services that may be covered by HCA, but are not covered benefits under this Contract.

3.2.7.22 Outreach and educational materials produced by CMS, found at http://www.cms.gov/Outreach-and-Education/Outreach-and-Education.html.

3.2.7.23 Specific information regarding EPSDT and childhood immunizations as described in the Contract.

3.2.7.24 Information regarding the availability of and how to access or obtain interpretation services and translation of written information at no cost to the enrollee (42 C.F.R. § 438.10(c)(5)(i and ii)).

3.2.7.25 How to obtain information in alternative formats (42 C.F.R. § 438.10(d)(2)).

3.2.7.26 The enrollee's right to and procedure for obtaining a second opinion.

3.2.7.27 The prohibition on charging enrollees for contracted services, the procedure for reporting charges the enrollee receives for contracted services to the Contractor, and circumstances under which an enrollee might be charged for services.

3.2.7.28 Information regarding appointment wait-time standards.

3.2.7.29 How to access dental benefits through the Medicaid fee for service system.

3.3 Equal Access for Enrollees & Potential Enrollees with Communication Barriers

The Contractor shall assure equal access for all enrollees and potential enrollees when oral or written language creates a barrier to such access for enrollees and potential enrollees with communication barriers (42 C.F.R. § 438.10).

3.3.1 Oral Information

3.3.1.1 The Contractor shall assure that interpreter services are provided for enrollees and potential enrollees with a primary language other than English, free of charge (42 C.F.R. § 438.10(c)(4)). Interpreter services shall be provided for all interactions between such enrollees or potential enrollees and the Contractor or any of its providers including, but not limited to:

3.3.1.1.1 Customer service,

3.3.1.1.2 All appointments with any provider for any covered service,

3.3.1.1.3 Emergency services, and

3.3.1.1.4 All steps necessary to file grievances and appeals including requests for Independent Review of Contractor decisions (RCW 48.43.535; WAC 246-305, 284-43).

3.3.1.2 The Contractor is responsible for payment for interpreter services for Contractor administrative matters including, but not limited to handling enrollee grievances and appeals.

3.3.1.3 HCA is responsible for payment for interpreter services provided by interpreter agencies contracted with the state for outpatient medical visits and hearings.

3.3.1.4 Hospitals are responsible for payment for interpreter services during inpatient stays.

3.3.1.5 Public entities, such as Public Health Departments, are responsible for payment for interpreter services provided at their facilities or affiliated sites.

3.3.1.6 Interpreter services include the provision of interpreters for enrollees and potential enrollees who are deaf or hearing impaired at no cost to the enrollee or potential enrollee (42 C.F.R. § 438.10(c)(4)).

3.3.2 Written Information

3.3.2.1 The Contractor shall provide all generally available and client-specific written materials in a language and format which may be understood by each individual enrollee and potential enrollee (42 C.F.R. § 438.10(c)(3) and 438.10(d)(1)(ii)).

3.3.2.1.1 If five percent (5%) or more of the Contractor's enrollees speak a specific language other than English, generally available materials, including the Contractor's handbook will be translated into that language.

3.3.2.1.2 For enrollees whose primary language is not translated or whose need cannot be addressed by translation under the preceding subsection as required by the provisions of this Section, the Contractor may meet the requirement of this Section by doing any one of the following:

3.3.2.1.2.1 Translating the material into the enrollee's or potential enrollee's primary reading language.

3.3.2.1.2.2 Providing the material in an audio format in the enrollee's or potential enrollee's primary language.

3.3.2.1.2.3 Having an interpreter read the material to the enrollee or potential enrollee in the enrollee's primary language.

3.3.2.1.2.4 Providing the material in another alternative medium or format acceptable to the enrollee or potential enrollee. The Contractor shall document the enrollee's or potential enrollee's acceptance of the material in an alternative medium or format (42 C.F.R. § 438.10(d)(1)(ii)).

3.3.2.1.2.5 Providing the material in English, if the Contractor documents the enrollee's or potential enrollee's preference for receiving material in English.

3.3.2.2 The Contractor shall ensure that all written information provided to enrollees or potential enrollees is accurate, is not misleading, is comprehensible to its intended audience, designed to provide the greatest degree of understanding, is written at the sixth grade reading level, and fulfills other requirements of the Contract as may be applicable to the materials (42 C.F.R. § 438.10(b)(1)).

3.3.2.3 HCA may make exceptions to the sixth grade reading level when, in the sole judgment of HCA, the nature of the materials do not allow for a sixth grade reading level or the enrollees' needs are better served by allowing a higher reading level. HCA approval of exceptions to the sixth grade reading level must be in writing.

3.3.2.4 Educational materials about topics such as Disease Management preventative services or other information used by the Contractor for health promotion efforts must be submitted to HCA, but do not require HCA approval as long as they do not specifically mention AH or the benefits provided under this Contract.

3.3.2.5 Educational materials that are not developed by the Contractor or developed under contract with the Contractor are not required to meet the sixth grade reading level requirement and do not require HCA approval.

3.3.2.6 All other written materials must have the written approval of HCA prior to use. For client-specific written materials, the Contractor may use templates that have been pre-approved in writing by HCA. The Contractor must provide HCA with a copy of all approved materials in final form.

3.4 **Electronic Outbound calls**

The Contractor may use an interactive, automated system to make certain outbound calls to enrollees.

3.4.1 The Contractor must submit call scripts to HCA no less than thirty (30) calendar days prior to the date the automated calls will begin. Approvable reasons for automated calls include:

3.4.1.1 Recertification of eligibility;

3.4.1.2 Outreach to new enrollees;

3.4.1.3 Reminders of events such as flu clinics;

3.4.1.4 Initial Health Screening;

3.4.1.5 Surveys;

3.4.1.6 Disease management information and reminders;

3.4.1.7 Appointment reminders/immunizations/well child appointments; and

3.4.1.8 Notification of new programs or assistance offered.

3.4.2 Under no circumstances will the Contractor use automated calls for care coordination activities, behavioral health-related calls or prescription verifications.

3.4.3 The Contractor shall ensure that if this service is provided by a third party, that either a subcontract or a Business Associate Agreement is in place and is submitted to HCA for review.

4 ENROLLMENT

4.1 Service Areas

The Contractor's policies and procedures related to Enrollment shall ensure compliance with the requirements described in this section.

4.1.1 The Contractor's service areas are described in Exhibit B. The Health Care Authority may modify Exhibit B, for service area changes as described in this Section.

4.2 Service Area Changes

4.2.1 With the written approval of HCA, the Contractor may either expand into an additional service area (an "Area Expansion") or increase its level of client assignments in a service area if it is already receiving voluntary enrollment, with or without a cap, in that service area (an "Area Increase").

4.2.2 To obtain an Area Expansion or an Area Increase, the Contractor must give written notice to HCA, along with evidence, as HCA may require, demonstrating the Contractor's ability to support the Area Expansion or Area Increase.

4.2.2.1 HCA may withhold approval of an Area Expansion or an Area Increase if, in HCA's sole judgment, the request is not in the best interest of HCA.

4.2.2.2 If approved, the timing of the Area Expansion or Area Increase will be at HCA's sole discretion.

4.2.3 The Contractor may not decrease its service areas or its level of participation in any service area except during Contract renewal, i.e., when the Contract is extended as provided herein.

4.2.4 If the U.S. Postal Service alters the zip code numbers or zip code boundaries within the Contractor's service areas, HCA shall alter the service area zip code numbers or the boundaries of the service areas with input from the affected contractors.

4.2.5 HCA shall determine, in its sole judgment, which zip codes fall within each service area.

4.2.6 HCA will use the enrollee's residential zip code to determine whether an enrollee resides within a service area.

4.3 Eligible Client Groups

The Health Care Authority shall determine eligibility for enrollment under this Contract. The Health Care Authority will provide the Contractor a list of Recipient Aid Categories (RACs) that are eligible to enroll in Apple Health (AH) managed care. The HCA will also provide the Contractor with a list of enrollees who are eligible for enrollment with the Contractor under the Maternity Benefits Program. For the purposes of this Contract, "AH Contractor", "enrollee" and "AH plan" also apply to the Maternity Benefit Program. Clients in the following eligibility groups at the time of enrollment are eligible for enrollment under this Contract.

4.3.1 Clients receiving Medicaid under Social Security Act (SSA) provisions for coverage of families receiving AH Family and clients who are not eligible for cash assistance who remain eligible for medical services under Medicaid.

4.3.2 Clients receiving Medicaid under the provisions of the ACA effective January 1, 2014.

4.3.3 Children, from birth through eighteen (18) years of age, eligible for Medicaid under expanded pediatric coverage provisions of the Social Security Act.

4.3.4 Pregnant Women, eligible for Medicaid under expanded maternity coverage provisions of the Social Security Act.

4.3.5 Children eligible for the Children's Health Insurance Program (CHIP).

4.3.6 Categorically Needy - Blind and Disabled Children and Adults who are not eligible for Medicare.

4.4 Client Notification

HCA shall notify eligible clients of their rights and responsibilities as managed care enrollees at the time of initial eligibility determination, after a break in eligibility greater than twelve (12) months or at least annually.

4.5 Exemption from Enrollment

A client may request exemption from enrollment for cause at any time. Each request for exemption will be reviewed by HCA pursuant to Chapter 182-538 or 182-505 WAC. When the client is already enrolled with the Contractor and wishes to be exempted, the exemption request will be treated as a termination of enrollment request consistent with the Termination of Enrollment provisions of this Section.

4.6 Enrollment Period

Subject to the Effective Date of Enrollment provisions of this Section, enrollment is continuously open. Enrollees shall have the right to change enrollment prospectively, from one AH managed care plan to another without cause, each month except as described in the Patient Review and Coordination (PRC) provisions of this Contract.

4.7 Enrollment Process

4.7.1 The Health Care Authority will assign the client, and all eligible family members, to the same AH managed care contractor in accord with the Assignment of Enrollees provisions of this Contract.

4.7.2 An enrollee may change his or her MCO, with or without cause, at any time. The effective date of the change in MCO shall be consistent with HCA's established enrollment timelines.

4.7.3 The client, the client's representative or responsible parent or guardian must notify the Health Care Authority if they want to choose another health plan.

4.7.4 The Health Care Authority will attempt to enroll all family members with the same AH managed care plan unless the following occurs:

4.7.4.1 A family member is placed into the Patient Review and Coordination (PRC) program by the Contractor or the Health Care Authority. The PRC placed family member shall follow the enrollment requirements described in the PRC provisions of this Contract. The remaining family members shall be enrolled with a single AH managed care plan of their choice.

4.7.4.2 The Health Care Authority grants an exception because the family members have conflicting medical needs that cannot be met by a single AH managed care contractor.

4.8 Effective Date of Enrollment

Except for a newborn whose mother is enrolled in an AH managed care plan, enrollment with the Contractor shall be effective on the later of the following dates:

4.8.1 If the enrollment is processed on or before the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first (1st) day of the month following the month in which the enrollment is processed;

4.8.2 If the enrollment is processed after the Health Care Authority cut-off date for enrollment, enrollment shall be effective the first (1st) day of the second month following the month in which the enrollment is processed; or

4.9 Newborns Effective Date of Enrollment

Newborns whose mothers are enrollees on the date of birth shall be deemed enrollees and enrolled in the same plan as the mother as follows:

4.9.1 Retrospectively for the month(s) in which the first twenty-one (21) days of life occur and prospectively, beginning the first (1st) of the month after the newborn is reported to the Health Care Authority.

4.9.2 If the newborn does not receive a separate client identifier from the Health Care Authority the newborn enrollment will be only available through the end of the month in which the first twenty-one (21) days of life occur.

4.9.3 If the mother's enrollment is ended before the newborn receives a separate client identifier from the Health Care Authority, the newborn's enrollment shall end the last day of the month in which the twenty first (21st) day of life occurs or when the mother's enrollment ends, whichever is sooner, except as provided in the provisions of the Enrollee Hospitalized at Termination of Enrollment of the Benefits Section of this Contract.

4.9.3.1 Adopted children shall be covered consistent with the provisions of Title 48 RCW.

4.9.3.2 No retroactive coverage is provided under this Contract, except as described in this section or by mutual agreement by both parties to this Contract.

4.10 Enrollment Data and Requirements for Contractor's Response

The Health Care Authority will provide the Contractor with data files with the information needed to perform the services described in this Contract.

4.10.1 Data files will be sent to the Contractor at intervals specified within the Health Care Authority 834 Benefit Enrollment and Maintenance Companion Guide, published by the Health Care Authority and incorporated by reference into this Contract.

4.10.2 The data file will be in the Health Insurance Portability and Accountability Act (HIPAA) compliant 834, Benefit Enrollment and Maintenance format (45 C.F.R. § 162.1503)

4.10.3 The data file will be transferred per specifications defined within the Health Care Authority Companion Guides.

4.10.4 The Contractor shall have ten (10) calendar days from the receipt of the data files to notify the Health Care Authority in writing of the refusal of an application for enrollment or any discrepancy regarding the Health Care Authority's proposed enrollment effective date. Written notice shall include the reason for refusal and must be agreed to by the Health Care Authority. The effective date of enrollment specified by the Health Care Authority shall be considered accepted by the Contractor and shall be binding if the notice is not timely or the Health Care Authority does not agree with the reasons stated in the notice. Subject to the Health Care Authority approval, the Contractor may refuse to accept an enrollee for the following reasons:

4.10.4.1 The Health Care Authority has enrolled the enrollee with the Contractor in a service area the Contractor is not contracted.

4.10.4.2 The enrollee is not eligible for enrollment under the terms of this Contract.

4.11 Termination of Enrollment

4.11.1 Voluntary Termination of Enrollment

4.11.1.1 Enrollees may request termination of enrollment for cause by submitting a written request to terminate enrollment to the Health Care Authority or by calling the Health Care Authority toll-free customer service number (42 C.F.R. § 438.56(d)(1)(i)).

4.11.1.2 For the purposes of this section, the following are cause for disenrollment:

4.11.1.2.1 The enrollee moves out of the Contractor's service area;

4.11.1.2.2 The Contractor does not, because of moral or religious objections, deliver the service the enrollee seeks;

4.11.1.2.3 The enrollee needs related services (for example birth and a tubal ligation) to be performed at the same time; not all related services are available within the network;

and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

4.11.1.2.4 Other reasons, including but not limited to: Poor quality of care, lack of access to services covered under this Contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

4.11.1.3 Enrollees denied disenrollment for cause or a plan change may request an appeal of the decision through a state hearing.

4.11.1.4 Except as provided in Chapter 182-538 or 182-505 WAC, the enrollment for enrollees whose enrollment is terminated will be prospectively ended. The Contractor may not request voluntary termination of enrollment on behalf of an enrollee.

4.11.2 Involuntary Termination of Enrollment Initiated by the Health Care Authority for Ineligibility.

4.11.2.1 The enrollment of any enrollee under this Contract shall be terminated if the enrollee becomes ineligible for enrollment due to a change in eligibility status.

4.11.3 When an enrollee's enrollment is terminated for ineligibility, the termination shall be effective:

4.11.3.1 The first (1st) day of the month following the month in which the enrollment termination is processed by the Health Care Authority if it is processed on or before the Health Care Authority cut-off date for enrollment or the Contractor is informed by the Health Care Authority of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the Health Care Authority.

4.11.3.2 Effective the first (1st) day of the second month following the month in which the enrollment termination is processed if it is processed after the Health Care Authority cut-off date for enrollment and the Contractor is not informed by the Health Care Authority of the enrollment termination prior to the first (1st) day of the month following the month in which it is processed by the Health Care Authority.

4.11.4 Newborns placed in foster care before discharge from their initial birth hospitalization shall have their Apple Health Managed Care enrollment terminated effective their date of birth.

4.11.5 Involuntary Enrollment Termination Initiated by the Health Care Authority for Comparable Coverage or Duplicate Coverage:

4.11.5.1 The Contractor shall submit to HCA a monthly report of enrollees with any other health care insurance coverage with any carrier, including the Contractor. The Contractor is not responsible for the determination of comparable coverage as defined in this subsection.

4.11.5.2 The Health Care Authority will involuntarily terminate the enrollment of any enrollee with duplicate coverage or comparable coverage as follows:

4.11.5.2.1 When the enrollee has duplicate coverage that has been verified by HCA, HCA shall terminate enrollment retroactively to the beginning of the month of duplicate coverage and recoup premiums as described in the Recoupments provisions of the Payment and Sanctions Section of this Contract.

4.11.5.2.2 When the enrollee has comparable coverage which has been verified by HCA, HCA shall terminate enrollment prospectively.

4.11.6 Involuntary Termination Initiated by the Contractor

4.11.6.1 To request involuntary termination of enrollment of an enrollee, the Contractor shall send written notice to HCA at hcamcprograms@hca.wa.gov.

4.11.6.1.1 HCA shall review each involuntary termination request on a case-by-case basis. The Contractor shall be notified in writing of an approval or disapproval of the involuntary termination request within thirty (30) working days of HCA's receipt of such notice and the documentation required to substantiate the request. HCA shall approve the request for involuntarily termination of the enrollee when the Contractor has substantiated in writing any of the following (42 C.F.R. § 438.56(b)(1)):

4.11.6.1.1.1 The enrollee purposely puts the safety or property of the Contractor, or the Contractor's staff, providers, patients, or visitors at risk; or

4.11.6.1.1.2 The enrollee engages in intentional misconduct, including refusing to provide information to the Contractor about third party insurance coverage; and

4.11.6.1.1.3 The enrollee received written notice from the Contractor of its intent to request the enrollee's termination of enrollment, unless the requirement for notification has been waived by HCA because the enrollee's conduct presents the threat of imminent harm to others. The Contractor's notice to the enrollee shall include the enrollee's right to use the

Contractor's grievance process to review the request to end the enrollee's enrollment.

4.11.6.2 The Contractor shall continue to provide services to the enrollee until HCA has notified the Contractor in writing that enrollment is terminated.

4.11.6.3 HCA will not terminate enrollment and the Contractor may not request disenrollment of an enrollee solely due to a request based on an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, uncooperative or disruptive behavior resulting from their special needs or mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

4.11.6.4 The Contractor shall have in place, and provide upon HCA's request, written methods by which it assures it does not request disenrollment for reasons other than those permitted under this Contract (42.C.F.R. § 438.56(b)(3)).

4.11.7 An enrollee whose enrollment is terminated for any reason, other than incarceration, at any time during the month is entitled to receive contracted services, at the Contractor's expense, through the end of that month.

4.11.8 In no event will an enrollee be entitled to receive services and benefits under this Contract after the last day of the month, in which his or her enrollment is terminated, except:

4.11.8.1 When the enrollee is hospitalized or in another inpatient facility covered by this Contract at termination of enrollment and continued payment is required in accord with the provisions of this Contract.

4.11.8.2 For the provision of information and assistance to transition the enrollee's care with another provider.

4.11.8.3 As necessary to satisfy the results of an appeal or hearing.

4.11.9 Regardless of the procedures followed or the reason for termination, if a disenrollment request is granted, or the enrollee's enrollment is terminated by HCA for one of the reasons described in Subsection 4.11.5 of this Contract, the effective date of the disenrollment will be no later than the first day of the second month following the month the request was made. If HCA fails to make a disenrollment determination within this timeframe, the disenrollment is considered approved.

5 PAYMENT AND SANCTIONS

5.1 Rates/Premiums

5.1.1 Subject to the Sanctions provisions of this Section, HCA shall pay a monthly premium for each enrollee in full consideration of the work to be performed by

the Contractor under this Contract. HCA shall pay the Contractor, on or before the fifteenth (15th) calendar day of the month based on the HCA list of enrollees whose enrollment is ongoing or effective on the first day of said calendar month. Such payment will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by the Centers for Medicare and Medicaid Services (CMS) under 42 C.F.R. § 438.726(b) or 42 C.F.R. § 438.730(e).

5.1.2 The Contractor shall reconcile the electronic benefit enrollment file with the premium payment information and submit differences it finds to HCA for resolution within sixty (60) calendar days receipt of the file.

5.2 Monthly Premium Payment Calculation

The monthly premium payment for each enrollee will be calculated as follows:

Premium Payment = Statewide Base Rate X Age/Sex Adjustment Factor X Risk Adjustment Factor X Geographical Adjustment Factor X Withhold Factor

Additional premium payments include Delivery Case Payment Rates and Low Birth Weight Baby Case Payment Rates, as described in Subsections 5.7 through 5.8 of this Contract.

5.2.1 The Statewide Base Rate is established by HCA and will vary between the Apple Health Family (AH Family), Apple Health State Children's Health Insurance Program (SCHIP), Apple Health Blind Disabled (AHBD), Apple Health Community Options Program Entry Services (COPES) and Apple Health Adult Coverage – (AHAC) populations. The base rates will initially be the same for all contractors, but may vary based on ACA related taxes and/or fees.

5.2.2 The Age/Sex Adjustment factors are established by HCA and will vary between the AH Family, SCHIP, AHBD, COPES and AHAC populations. The age/sex factors will be the same for all contractors.

5.2.3 The Geographical Adjustment Factors are recalculated by HCA annually to reflect changes in the relative cost of providing care in different geographical areas of the State. The Geographical Adjustment Factors and geographic service areas are the same for all contractors but may vary between AH Family, SCHIP, AHBD, COPES, and AHAC populations.

5.2.4 The Risk Adjustment Factors will be as established for the rates effective January 1, 2015 by HCA for the AH Family, SCHIP, AHBD, and COPES populations to reflect differences in the relative health status of the populations enrolled with the Contractors. The Risk Adjustment Factors are calculated by geographical region and by Contractor. For the AHAC population, a placeholder risk adjustment factor will be applied to each contractor's rates to reflect the relative PMPM costs of the program for the period January – June 2015. This AHAC risk adjustment is intended for the purpose of cash flow management only and is not expected to impact the final revenue paid for the program after risk mitigation for 2015.

5.2.5 The Withhold Factor is intended to hold back one percent (1%) of the capitation payments excluding any SNAF, PAP, or Trauma funding. The Withhold Factor is calculated by multiplying 0.99 times the percentage of the base rate represented by the non-SNAF/PAP/Trauma portion for each population. The amount withheld from the monthly premium payment will be released upon successful reconciliation of the Contractor's encounter data per subsection 5.11.6 of this Contract.

5.2.6 HCA shall automatically generate newborn premiums upon enrollment of the newborn. For newborns whose premiums HCA does not automatically generate, the Contractor shall submit a premium payment request to HCA within 365 calendar days of the date of birth. HCA shall pay within sixty (60) days of receipt of the premium payment request. HCA shall pay premiums through the end of the month in which the twenty-first (21st) day of life occurs.

5.2.7 HCA shall make a full monthly payment to the Contractor for the month in which an enrollee's enrollment is terminated except as otherwise provided in this Contract.

5.2.8 The Contractor shall be responsible for contracted services provided to the enrollee in any month for which HCA paid the Contractor for the enrollee's care under the terms of this Contract.

5.3 Annual Fee on Health Insurance Providers

5.3.1 The Contractor is subject to a fee (the "Annual Fee") imposed by the federal government under Section 9010 of the Patient Protection and Affordable Care Act, Pub. L. 111-148 (124 Stat. 119 (2010)), as amended by Section 10905 of PPACA, and as further amended by Section 1406 of the Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152 (124 Stat. 1029 (2010)) (collectively, "PPACA"), unless specifically exempt under federal law.

5.3.2 If the Contractor is responsible for payment of a percentage of the Annual Fee for all health insurance providers, the Contractor's obligation is determined by the ratio of the Contractor's net written premiums for the preceding year compared to the total net written premiums of all covered entities subject to the Annual Fee for the same year.

5.3.3 The amount of the Annual Fee attributable to the Contractor and attributable specifically to the Contractor's premiums under this Contract ("Contractor's Allocated Fee") could affect the actuarial soundness of the premiums received by the Contractor from HCA for the contract year during which the Annual Fee is assessed.

5.3.4 A dollar amount reflecting the Contractor's Allocated Fee, which shall also include an adjustment for the impact of non-deductibility of the Annual Fee for Federal and state tax purposes, including income and excise taxes ("Contractor's

Adjusted Fee"), shall be payable to the Contractor under this Contract, unless the Contractor is exempt from the Annual Fee under federal law.

5.3.5 HCA shall consult with the Contractor and determine an estimated amount of the Contractor's Adjusted Fee based on the pro rata share of the preliminary notice of the fee amount, as transmitted by the United States Internal Revenue Service to the Contractor, attributable to the Contractor's net written premiums under this Contract.

5.3.6 Capitation payments for the period to which the tax applies will be retroactively adjusted to account for this fee. The net aggregate change in capitation payments for the period based on the retroactive rate change will be paid to the Contractor.

5.3.7 HCA shall make a good-faith effort to make the estimated payment to the Contractor thirty (30) calendar days before the deadline for payment by the Contractor.

5.3.8 The adjustment shall be reconciled, no later than ninety (90) calendar days following the receipt of the final notice of the fee from the United States Internal Revenue Service, through a retroactive adjustment to the capitation rates for the applicable period and an additional payment to the Contractor, or a refund from the Contractor, as applicable, once the complete data is available to calculate the Contractor's Adjusted Fee.

5.3.9 The Contractor agrees to not pursue any legal action whatsoever against HCA or its officers, employees, or agents with respect to the amount of the Contractor's Allocated Fee or Contractor's Adjusted Fee.

5.4 **Gain Share Program**

5.4.1 HCA will perform gain share calculations for AH Family, SCHIP, AHBD, and COPES populations. Apple Health Adult Coverage (AHAC) is not eligible for gain sharing. Separate calculations of Gain Sharing are done due to differences in assumed administrative loads included in the rates for each program. Upon completion of the separate calculations, the results for the four populations will be aggregated to determine any net Gain Share payment. Gain Sharing is calculated separately for each Contractor.

5.4.2 The following methods will be used to calculate the Gain Share components:

5.4.2.1 Total Revenue is the sum of all Pre-Tax Capitation Rates, Delivery Case Rate Payments and Low Birth Weight Case Payments. Total Revenue also assumes full recovery by the Contractor of encounter data related withheld funds, regardless of whether those funds were actually recovered. Pre-tax capitation rates means that the Health Insurer Fee related revenue will be excluded from this computation.

5.4.2.2 Total Net Revenue is equal to Total Revenue, net of any SNAF, PAP and Trauma components of the capitation revenue.

5.4.2.3 Revenue for Health Care Expenses is equal to Total Net Revenue less an assumed administrative load. [(Revenue-supplemental payments) x (1- administrative load)] Actual administrative expenses will not be included in the computation.

Assumed administrative load is as follows:

AH Family	11.0%
SCHIP	11.3%
AHBD	8.7%
COPES	8.6%

5.4.2.4 Net Health Care Expenses will be based on the actual service expenses less any reimbursements from third party reimbursements (such as pharmacy rebates, net reinsurance costs or third party liability offsets) and less supplemental payments plus direct Medical Management costs as defined by NAIC and GAAP guidelines not to exceed two percent (2%) of Revenue and excluding any overhead allocations. The Contractor will be requested to report its health care expenses for the year with any adjustments and run out claims through June 30th. That updated report will be due to HCA by July 15th.

5.4.2.5 Contractor's Gain/Loss will be calculated for each population using the following formula:

Revenue for Health Care Expenses - Net Health Care Expenses (based on the actual incurred expenses for health care) **= Net Gain/Loss** (for the health care services provided by population).

5.4.2.6 The net gain/loss divided by the Total Net Revenue will provide a percentage of the gain/loss which will be compared to the gain sharing thresholds established by HCA.

5.4.3 Under the Gain Share Program, HCA will share in a significant excess of the Total Net Revenue for Health Care Expenses over the Net Health Care Expenses experienced by the Contractor as defined in subsection 5.4.4 of this Contract. Six (6) months following the end of the calendar year, using the financial reports provided by the Contractor, a simple profit and loss statement will be developed for the health services portion for each of the four populations.

5.4.4 After aggregating the results for all four populations, if the Contractor experiences gain exceeding three percent (3%), HCA will share equally in the gain between three percent (3%) and five percent (5%). HCA will recover all gains exceeding five percent (5%). The Contractor will only be required to reimburse HCA if it experiences an actual gain above the three-percent (3%) corridor.

Example:

The following example illustrates how the Gain Share Program would be applied to an individual Contractor for the AHBD population and in aggregate.

Total Revenue		$160,000,000
SNAF, PAP and Trauma Revenue		- $20,000,000
Total Net Revenue		$140,000,000
Admin %	8.7%	
Revenue for Heath Care Expenses		$127,820,000
Net Health Care Expenses		-$119,400,000
Net Gain		$ 8,420,000

Aggregation:

	Premium	**Gain (Loss)**
AHBD	$140,000,000	$8,420,000
COPES	$50,000,000	$1,000,000
Family	$200,000,000	$10,000,000
SCHIP	$40,000,000	($2,000,000)
Total	$430,000,000	$17,420,000

3% Gain = $430,000,000 x 0.03 = $12,900,000

Gain to be shared = $17,420,000 – 12,900,000 = $4,520,000

Reimbursement to State = 50% x $4,520,000 = $2,260,000

Note: Reimbursement due = 50% of gain between 3% and 5%, and 100% of gain in excess of 5%

5.5 Expansion Risk Mitigation

5.5.1 The risk mitigation for the Expansion population will be performed on a retrospective basis. For the purpose of these calculations, revenue and claim costs will exclude all items not included in the capitation rate development (certain Hepatitis C drugs) or items not fully loaded for administrative costs (SNAF, FQHC enhancements). It will also exclude revenue and expenses associated with the Health Insurer Fee.

5.5.2 The Expansion population will be separated into two subgroups: Transitional and New members. The Transitional group will be defined as those with a Medicaid ID that can be identified in the Medicaid eligibility system any time during the period from July 2012 through December 2013. All other members will be defined as New. Note that Expansion members enrolled in Basic Health during the prior period were not previously given a Medicaid ID number and will be assigned to the New population even though they had prior State coverage.

5.5.3 Any costs allowed in the computation by CMS other than direct encounter based payments or pre-paid at risk capitation amounts must be allocated between Transitional and New members in an equitable manner. For example, provider incentive payments tied only to the Transitional members would not be allowed.

5.5.4 For the Transitional members, claim costs will be accumulated for Calendar Year 2015 enrolled members for claims incurred in 2015 with six months of run-out. Incurred but not paid claims will be estimated to compute the total expected claim cost for the period. The target revenue for each MCO will be calculated as the total expected claim cost divided by 0.86. If the actual revenue paid for Transitional members exceeds the target revenue for an MCO, that MCO will refund the difference. If the target revenue exceeds the actual revenue, a payment will be made to the MCO for the difference.

5.5.5 Note that the total expected claim cost may change as a result of the revenue settlement process as some providers are paid as a percentage of revenue. Such adjustments to the total expected claim costs will be accounted for in the calculation.

5.5.6 For New members, the following three step process will be followed:

5.5.6.1 Step 1. Risk Adjustment.

5.5.6.1.1 Calendar year 2015 experience (eligible member months and incurred claim dates) for the Apple Health Adult Coverage (Medicaid Expansion) population defined as New.

5.5.6.1.2 Allow for six months of run out with appropriate IBNP adjustment.

5.5.6.1.3 Concurrent risk adjustment.

5.5.6.1.4 Retrospective redistribution of revenue based on risk scores.

5.5.6.1.5 Revenue redistribution will be budget neutral for HCA/CMS.

5.5.6.2 Step 2. Constant percentage adjustment to revenue.

5.5.6.2.1 Establish a pricing target medical loss ratio (MLR) of eighty-seven and one half percent (87.5%).

5.5.6.2.2 A uniform premium adjustment will be applied to all Contractors to ensure that the composite of all Contractor MLR results is within one and one half percent (1.5%) of the pricing target.

5.5.6.2.3 If the composite MLR is greater than eighty-nine percent (89%), all Contractors will be paid additional premium as a percentage increase in revenue (inclusive of capitation payments, DCR payments and withhold recoveries) such that the composite MLR will equal eighty-nine percent (89%).

5.5.6.2.4 If the composite MLR is less than eighty-six percent (86%), all Contractors will refund premium as a percentage of revenue (inclusive of capitation payments, DCR payments and withhold recoveries) such that the composite MLR will equal eighty-six percent (86%).

5.5.6.2.5 If the composite MLR is between eighty-six percent (86%) and eighty-nine percent (89%), then no constant percentage of premium adjustment will occur in this step.

5.5.6.3 Step 3. Contractor specific risk corridors.

5.5.6.3.1 Any Contractor, after adjustments from Steps 1 and 2 above, with an MLR greater than ninety-two percent (92%) will receive additional premium equal to half of the amount necessary to reduce the MLR to ninety-two percent (92%).

5.5.6.3.2 Any Contractor, after adjustments from Steps 1 and 2 above, with an MLR less than eighty-six percent (86%) will refund premium equal to half of the amount necessary to increase the MLR to eighty-six percent (86%).

5.5.6.3.3 No risk corridor adjustments will be made for Contractors with an MLR between eighty-six percent (86%) and ninety-two percent (92%) after adjustments from Steps 1 and 2.

5.6 **Recoupments**

Unless mutually agreed by the parties in writing, the HCA shall only recoup premium payments and retroactively terminate enrollment for individual enrollees:

5.6.1 With duplicate coverage.

5.6.2 Deceased prior to the month of enrollment. Premium payments shall be recouped effective the first day of the month following the enrollee's date of

death.

5.6.3 Retroactively have their enrollment terminated consistent with this Contract.

5.6.4 Found ineligible for enrollment with the Contractor, provided the HCA has notified the Contractor before the first day of the month for which the premium was paid.

5.6.5 An inmate at a correctional facility in any full month of enrollment.

5.6.6 When an audit determines that payment was made in error.

5.6.7 The Contractor may recoup payments made to providers for services provided to enrollees during the period for which the HCA recoups premiums for those enrollees. If the Contractor recoups said payments, providers may submit appropriate claims for payment to the Health Care Authority through its fee-for-service program, if the enrollee was eligible for services.

5.6.8 When the HCA recoups premiums and retroactively terminates the enrollment of an enrollee, the HCA will not recoup premiums and retroactively terminate the enrollment of any other family member, except for newborns whose mother's enrollment is terminated for duplicate coverage.

5.7 Delivery Case Rate Payment

A one-time payment shall be made to the Contractor for labor and delivery expenses for AH Family, SCHIP and AHAC enrollees enrolled with the Contractor during the month of delivery. The Delivery Case Rate shall only be paid to the Contractor if the Contractor has incurred and paid direct costs for labor and delivery based on encounter data received and accepted by HCA. AHBD and COPES enrollees are not eligible for these payments. Delivery includes both live and stillbirths, but does not include miscarriage, induced abortion, or other fetal demise not requiring labor and delivery to terminate the pregnancy.

5.8 Low Birth Weight Baby Case Payment (LBW-BCP)

A one-time payment shall be made to the Contractor for Low Birth Weight Baby related expense for AH Family and SCHIP enrollees enrolled with the Contractor during the month of a qualifying low birth event. The LBW-BCP payment shall be paid to the Contractor if the following conditions are met:

5.8.1 HCA determines the Contractor incurred and paid direct costs for a qualifying low birth weight even based on valid encounter data received and accepted by HCA.

5.8.2 Qualifying events that derive one of the following APR-DRG codes or code equivalents: 588, 589, 591, 593, 602, 603, 607, 608, 609, 630, or 631 will be evaluated by HCA to determine the AP-DRG code that would have been derived by the grouper system using the logic in place prior to July 1, 2014.

5.8.3 Through that analysis, those encounters that return a derived AP-DRG code of 602, 604, 606, 607, 609, 615, 616, or 622 shall qualify for the LBW-BCP.

5.8.4 The qualifying claim must have a Contractor paid amount of more than $75,000.

5.8.5 The LBW-BCP is not modified by any rate adjustment factors.

5.8.6 The HCA will pay a maximum of two hundred sixty-three (263) LBW-BCP for the contract year.

5.8.7 Only AH Family and SCHIP enrollees are eligible for these payments. The maximum number of payments is for all Contractors combined.

5.8.8 In the event that the maximum number of payments has been reached, the ProviderOne submitted date and time of the qualifying encounter will determine the order of the claims for payment.

5.9 Targeted Service Enhancements

The per member per month premium amounts established by HCA will include additional funding for targeted services.

5.9.1 Provider Access Payment (PAP) Program

5.9.1.1 HCA will increase the per member premium payments to the Contractor for AH Family and AHB enrollees for enhanced payments to providers.

5.9.1.2 HCA will calculate the per member premium based on the estimated funding to be collected and the estimated member month premiums to be paid over the contracted period.

5.9.2 Hospital Safety Net (Safety Net)

5.9.2.1 HCA will increase the per member premium payments to support increased payment for hospital services provided by Washington hospitals to Medicaid enrollees. Computation of these amounts included covered services provided in psychiatric and rehabilitation hospitals.

5.9.2.2 HCA will calculate the per member premium based on the estimated funding to be collected and the estimated member month premiums to be paid over the contracted period.

5.10 Overpayments or Underpayments of Premium

If, at HCA's the sole discretion, HCA determines as a result of data errors or inadequacies, policy changes beyond the control of the Contractors, or other causes there are material errors or omissions in the development of rates, HCA may make prospective and/or retrospective modifications to the rates, as necessary. At the explicit written approval of HCA, the Contractor can elect to make a lump sum or similar arrangement for payment in lieu of modifications to the rate.

5.11 **Encounter Data**

5.11.1 For purposes of this Subsection:

5.11.1.1 "Encounter" means a single health care service or a period of examination or treatment.

5.11.1.2 "Encounter data" means records of health care services submitted as electronic data files created by the Contractor's system in the standard 837 format and the National Council for Prescription Drug Programs (NCPDP) Batch format.

5.11.1.3 "Encounter record" means the number of service lines or products submitted as line items in the standard 837 format or the National Council for Prescription Drug Programs (NCPDP) Batch format.

5.11.1.4 "Duplicate Encounter" means multiple encounters where all fields are alike except for the ProviderOne Transaction Control Numbers (TCNs) and the Contractors Claim Submitter's Identifier or Transaction Reference Number.

5.11.2 The Contractor shall comply with the all of the following:

5.11.2.1 Designate a person dedicated to work collaboratively with HCA on quality control and review of encounter data submitted to HCA.

5.11.2.2 Submit to HCA complete, accurate, and timely data for all services for which the Contractor has incurred any financial liability, whether directly or through subcontracts or other arrangements in compliance with current encounter submission guidelines as published by HCA and that adhere to the following data quality standards:

5.11.2.2.1 Encounter data must be submitted to HCA at a minimum monthly, and no later than thirty (30) calendar days from the end of the month in which the Contractor paid the financial liability;

5.11.2.2.2 Submitted encounters and encounter records must pass all HCA ProviderOne system edits with a disposition of accept and listed in the Encounter Data Reporting Guide or sent out in communications from HCA to the Contractor; and

5.11.2.2.3 Submitted encounters or encounter records must not be a duplicate of a previously submitted and accepted encounter or encounter record unless submitted as an adjustment or void per HIPAA Transaction Standards.

5.11.2.3 These data quality standards are listed within this Contract and incorporated by reference into this Contract. The Contractor shall make changes or corrections to encounter data and/or any systems, processes or data transmission formats as needed to comply with HCA's data quality standards as defined and subsequently amended.

5.11.3 The Contractor must report the paid date and amount paid for each encounter. The "amount paid" data is considered the Contractor's proprietary information and is protected from public disclosure under RCW 42.56.270(11). Amount paid shall not be utilized in the consideration of a Contractor's assignment percentage or in the evaluation of a Contractor's performance.

5.11.4 HCA shall perform encounter data quality reviews to ensure receipt of complete and accurate encounter data for program administration and rate setting.

5.11.5 The Contractor must certify the accuracy and completeness of all encounter data concurrently with each file upload (42 C.F.R. § 438.606). The certification must affirm that:

5.11.5.1 The Contractor has reported to HCA for the month of (indicate month and year) all paid claims for all claim types;

5.11.5.2 The Contractor has reviewed the claims data for the month of submission; and

5.11.5.3 The Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer attest that based on best knowledge, information, and belief as of the date indicated, all information submitted to HCA in the submission is accurate, complete, truthful, and they hereby certify that no material fact has been omitted from the certification and submission.

5.11.6 The Contractor shall submit Encounter Data/Financial Summary Reconciliation (Form C), attached to this Contract as Attachment 1, to accompany every certified encounter submission. "Form C" must provide a high level summary by category, including total claims, total claim lines and total paid amounts for each service category, for all encounters included within a certified submission. Each program (AHAC, SCHIP, AHBD, etc.) the Contractor provides should be listed on a separate "Form C". Each program (AHAC, SCHIP, AHBD, AHFC, etc.) the Contractor provides should be listed on a separate "Form C".

5.11.7 The Contractor must validate the accuracy and completeness of all encounter data compared to the year-to-date general ledger of paid claims.

5.11.7.1 Within sixty (60) days of the end of each calendar quarter, the Contractor shall provide aggregate totals of all encounter data submitted and accepted within required timing in 5.11.2.2.1 of this Subsection during that quarter using the Apple Health Quarterly Encounter/General Ledger Reconciliation (Form D), attached to this Contract as Attachment 2, and shall reconcile the cumulative encounter data submitted and accepted for the quarter and contract year with the general ledger paid claims for the quarter. The Contractor shall provide justification for any discrepancies. HCA will approve or reject the discrepancy justifications and notify the

Contractor of the decision one hundred twenty (120) days of the end of each calendar quarter.

5.11.7.2 The Contractor's encounter data submitted and accepted on Form D will be validated against submitted and accepted data captured within HCA's ProviderOne System and must be within one percent (1%) of what HCA captured.

5.11.7.2.1 If the Contractor's encounter data submitted and accepted on Form D is not within one percent (1%) of the submitted and accepted encounter data captured within HCA's ProviderOne System, HCA will provide the Contractor a list of ProviderOne TCNs and associated Contractor's Transaction Reference Numbers. The Contractor must explain the difference in the encounter data provided by HCA with the encounter data submitted and accepted on Form D for that quarter.

5.11.7.3 For any Contractor that is new to the Apple Health program as of 2015 and did not have an Apple Health contract under any name in 2014;

5.11.7.3.1 The reconciliation of the encounter data for the first calendar quarter of 2015 that is performed according to the timeline in 5.11.6.1 of this subsection will be done to test the reconciliation process and to identify discrepancies that would prevent release of the amounts withheld for that quarter to the Contractor. The Contractor will have until the completion of the second reconciliation process of the second calendar quarter of encounter data to correct the discrepancies found through the initial reconciliation of the first quarter encounter data.

5.11.7.3.2 Following the quarterly reconciliation process for the second calendar quarter of 2015, if the discrepancy between the encounter data submitted and accepted within required timing in 5.11.2.2.1 of this subsection and the general ledger paid claims for the first two calendar quarters of 2015 cannot be justified for reasons other than encounter data quality and completeness, and that discrepancy is more than one percent (1%) of the anticipated amount to reconcile to the general ledger amounts, HCA will notify the Contractor and will retain the amounts withheld from the monthly premium payments for the first two calendar quarters of 2015.

5.11.7.3.3 Following quarterly reconciliation process for the third and fourth quarters of 2015, if the discrepancy between the encounter data submitted and accepted within required timing in 5.11.2.2.1 of this subsection and the general

ledger paid claims for the quarter being reconciled cannot be justified for reasons other than encounter data quality and completeness, and that discrepancy is more than one percent (1%) of the anticipated amount to reconcile to the general ledger amounts, HCA will notify the Contractor and will retain the amounts withheld from the monthly premium payments for the prior calendar quarter.

5.11.7.4 For any Contractor that had an Apple Health contract under any name in 2014 and is returning as a Contractor in 2015:

5.11.7.4.1 Following each quarterly reconciliation process for all calendar quarters of 2015, if the discrepancy between the encounter data submitted and accepted within required timing in 5.11.2.2.1 of this subsection and the general ledger paid claims for the quarter being reconciled cannot be justified for reasons other than encounter data quality and completeness, and that discrepancy is more than one percent (1%) of the anticipated amount to reconcile to the general ledger amounts, HCA will notify the Contractor and will retain the amounts withheld from the monthly premium payments for the prior calendar quarter.

5.11.7.5 The release of amounts withheld shall apply only to the calendar months being reconciled as part of that quarter's reconciliation process. Failure to demonstrate that the encounter data submitted and accepted within required timing reconciles to the general ledger amounts within one percent (1%) per the processes included in 5.11.6.1 through 5.11.6.3 of this Subsection will result in loss of the amounts withheld for the quarter(s).

5.11.8 HCA collects and uses this data for many reasons such as: Audits, investigations, identifications of improper payments and other program integrity activities, federal reporting (42 C.F.R. § 438.242(b)(1)), rate setting and risk adjustment, service verification, managed care quality improvement program, utilization patterns and access to care; HCA hospital rate setting; pharmacy rebates and research studies.

5.11.9 Additional detail can be found in the Encounter Data Reporting Guide published by HCA and incorporated by reference into this Contract:

5.11.9.1 HCA may change the Encounter Data Reporting Guide with ninety (90) calendar days' written notice to the Contractor.

5.11.9.2 The Encounter Data Reporting Guide may be changed with less than ninety (90) calendar days' notice by mutual agreement of the Contractor and HCA.

5.11.9.3 The Contractor shall, upon receipt of such notice from HCA, provide notice of changes to subcontractors.

5.12 Retroactive Premium Payments for Enrollee Categorical Changes

Enrollees may have retroactive changes in their eligibility category. Such changes will only affect premium payments prospectively.

5.13 Renegotiation of or Changes in Rates

The rates set forth herein shall be subject to renegotiation during the Contract period only if HCA, in its sole judgment, determines that it is necessary due to a change in federal or state law or other material changes, beyond the Contractor's control, which would justify such a renegotiation. If HCA, in its sole judgment, determines there is a change in benefits during the term of the Contract that will have a material impact on Contractor costs, HCA may change rates to allow for the benefit change.

5.13.1 The Contractor shall report to HCA on its coordination of benefits activities and its data collection methods for the preceding state fiscal year, July 1 through June 30, 2014 by March 1, 2015 in a format provided by HCA.

5.14 Reinsurance/Risk Protection

The Contractor may obtain reinsurance for coverage of enrollees provided that the Contractor remains ultimately liable to HCA for the services rendered.

5.15 Provider Payment Reform

HCA intends to reform provider payment. The Contractor shall collaborate and cooperate with HCA on provider payment reform. The Contractor will provide in a timely manner any information necessary to support HCA's analyses of provider payment.

5.16 Experience Data Reporting

The Contractor shall annually provide information regarding its cost experience related to the provision of the services required under this Contract. The experience information shall be provided directly to an actuary designated by HCA. The designated actuary will determine the timing, content, format and medium for such information. HCA requires this information in order to be able to set actuarially sound managed care rates.

5.17 Payments to Hospitals

5.17.1 Payments must be made to hospitals subject to the Hospital Safety Net Assessment in accord with Chapter 74.60 RCW as follows:

5.17.1.1 HCA will provide information to the Contractor to facilitate its payments to the hospitals subject to the Hospital Safety Net Assessment.

5.17.2 The Contractor will pay all hospitals at least the Inpatient and Outpatient rates published by HCA for its fee-for-service program.

5.17.3 Treatment of Inpatient Hospital Claims for Certified Public Expenditure (CPE) Hospitals.

5.17.3.1 Because HCA can leverage additional federal funds for fee-for-service

inpatient claims at CPE facilities, these expenditures were carved out of the premium payments for the blind and disabled populations moved from fee-for-service (FFS) to Healthy Options beginning July 1, 2012. HCA will separately identify the enrollees subject to the carve-out. If an enrollee's eligibility category changes to AHBD while he or she is an inpatient at a CPE hospital:

5.17.3.1.1 The Contractor is responsible for the claim when the AHBD eligibility does not cover the entire hospitalization.

5.17.3.1.2 HCA is responsible for the inpatient claim when the enrollee's AHBD eligibility covers the entire hospitalization.

5.17.3.2 While premiums are net of CPE inpatient hospital claims, the Contractor does remain at risk for these fee-for-service claims if they exceed expectations. CPE inpatient hospital expenditure benchmarks will be computed on a per-member-per month (PMPM) basis, and will vary by category, age, gender and region.

5.17.3.3 After the end of each calendar year, HCA will compute aggregate CPE hospital FFS expenditures attributable to the Contractor, based upon actual enrollment. Actual CPE hospital expenditures for all Contractor enrolled member months will be compared to the Contractor specific benchmarks that take into account changes in utilization and risk. If actual expenditures exceed the established benchmarks, the Contractor will reimburse the State for the amount of the excess. The State will not make payments to any MCO if expenditures are below benchmark amounts.

5.17.3.4 The following is a list of CPE Hospitals:

- University of Washington Medical Center
- Harborview Medical Center
- Cascade Valley Hospital
- Evergreen Hospital and Medical Center
- Kennewick General Hospital
- Olympic Medical Center
- Samaritan Hospital – Moses Lake
- Skagit County Hospital District #2 – Island
- Skagit Valley Hospital
- Valley General Hospital – Monroe
- Valley Medical Center - Renton

5.17.3.5 The Contractor shall authorize inpatient services at CPE hospitals. The HCA shall honor the Contractor's authorizations for the Contractor's provision of services related to inpatient claims.

5.18 Payment for Services by Non-Participating Providers

5.18.1 The Contractor shall limit payment for emergency services furnished by any provider who does not have a contract with the Contractor to the amount that would be paid for the services if they were provided under HCA's, Medicaid Fee-For-Service (FFS) program (Deficit Reduction Act of 2005, Public Law No. 109-171, Section 6085).

5.18.2 Except as provided herein for emergency services, the Contractor shall coordinate with and pay a non-participating provider that provides a service to enrollees under this Contract no more than the lowest amount paid for that service under the Contractor's contracts with similar providers in the state. For the purposes of this subsection, "contracts with similar providers in the state" means the Contractor's contracts with similar providers to provide services under the managed care program when the payment is for services received by a managed care enrollee.

5.18.3 The Contractor shall track and record all payments to participating providers and non-participating providers in a manner that allows for the reporting to HCA the number, amount, and percentage of claims paid to participating providers and non-participating providers separately. The Contractor shall also track, document and report to HCA any known attempt by non-participating providers to balance bill enrollees.

5.18.4 The Contractor shall provide annual reports to the HCA for the preceding state fiscal year July 1st through June 30th. The reports shall indicate the proportion of services provided by the Contractor's participating providers and non-participating providers, by county, and including hospital-based physician services in a format provided by HCA. Contractor shall submit the report to HCA no later than November 1st of each year, or as required by HCA.

5.19 Data Certification Requirements

Any information and/or data required by this Contract and submitted to HCA shall be certified by the Contractor as follows (42 C.F.R. § 438.242(b)(2) and 438.600 through 438.606):

5.19.1 Source of certification: The information and/or data shall be certified by one of the following:

5.19.1.1 The Contractor's Chief Executive Officer.

5.19.1.2 The Contractor's Chief Financial Officer.

5.19.1.3 An individual who has delegated authority to sign for, and who reports directly to, the Contractor's Chief Executive Officer or Chief Financial Officer.

5.19.2 Content of certification: The Contractor's certification shall attest, based on best knowledge, information, and belief, to the accuracy, completeness and

truthfulness of the information and/or data.

5.19.3 Timing of certification: The Contractor shall submit the certification concurrently with the certified information and/or data.

5.19.4 HCA will identify the specific data that requires certification.

5.20 Sanctions

5.20.1 If the Contractor fails to meet one or more of its obligations under the terms of this Contract or other applicable law, HCA may impose sanctions by withholding from the Contractor up to five percent of its scheduled payments or may suspend or terminate assignments and re-enrollments (defined as connecting an enrollee who lost eligibility with the Contractor which he or she was enrolled in when he or she lost enrollment).

5.20.2 HCA shall notify the Contractor of any default in writing, and shall allow a cure period of up to thirty (30) calendar days, depending on the nature of the default. If the Contractor does not cure the default within the prescribed period, HCA may withhold payment, assignments, or re-enrollments from the end of the cure period until the default is cured or any resulting dispute is resolved in the Contractor's favor.

5.20.2.1 HCA will notify the Contractor in writing of the basis and nature of any sanctions, and if, applicable, provide a reasonable deadline for curing the cause for the sanction before imposing sanctions. The Contractor may request a dispute resolution, as described in the Disputes provisions of the General Terms and Conditions Section of this Contract, if the Contractor disagrees with HCA's position.

5.20.2.2 HCA, CMS, or the Office of the Inspector General (OIG) may impose intermediate sanctions in accord with applicable law, including but not limited to 42 C.F.R. § 438.700, 42 C.F.R. § 438.702, 42 C.F.R. § 438.704, 45 C.F.R. § 92.36(i)(1), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210 against the Contractor for:

5.20.2.2.1 Failing to provide medically necessary services that the Contractor is required to provide, under law or under this Contract, to an enrollee covered under this Contract.

5.20.2.2.2 Imposing on enrollees premiums or charges that are in excess of the premiums or charges permitted under law or under this Contract.

5.20.2.2.3 Acting to discriminate against enrollees on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll an enrollee, except as permitted under law or under this Contract, or any practice that would reasonably be

expected to discourage enrollment by enrollees whose medical condition or history indicates probable need for substantial future medical services.

5.20.2.2.4 Misrepresenting or falsifying information that it furnishes to CMS, HCA, an enrollee, potential enrollee, or any of its subcontractors.

5.20.2.2.5 Failing to comply with the requirements for physician incentive plans.

5.20.2.2.6 Distributing directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by HCA or that contain false or materially misleading information.

5.20.2.2.7 Violating any of the other requirements of Sections 1903(m) or 1932 of the Social Security Act, and any implementing regulations.

5.20.2.2.8 HCA may base its determinations regarding Contractor conduct on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

5.20.2.2.9 Except for matters and penalties covered under Chapters 74.09 and 74.66 RCW et seq., Intermediate sanctions may include:

5.20.2.2.10 Civil monetary sanctions in the following amounts:

5.20.2.2.10.1 A maximum of $25,000 for each determination of failure to provide services; misrepresentation or false statements to enrollees, potential enrollees or healthcare providers; failure to comply with physician incentive plan requirements; or marketing violations.

5.20.2.2.10.2 A maximum of $100,000 for each determination of discrimination; or misrepresentation or false statements to CMS or HCA.

5.20.2.2.10.3 A maximum of $15,000 for each potential enrollee HCA determines was not enrolled because of a discriminatory practice subject to the $100,000 overall limit.

5.20.2.2.10.4 A maximum of $25,000 or double the amount of the charges, whichever is greater, for charges to enrollees that are not allowed under managed care. HCA will deduct from the penalty the amount charged and return it to the enrollee.

5.20.2.2.11 Appointment of temporary management for the Contractor as provided in 42 C.F.R. § 438.706. HCA will only impose temporary management if it finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act. Temporary management will be imposed in accord with RCW 48.44.033 or other applicable law.

5.20.2.2.12 Suspension of all new enrollments, including default enrollment, after the effective date of the sanction. HCA shall notify current enrollees of the sanctions and that they may terminate enrollment at any time.

5.20.2.2.13 Suspension of payment for enrollees enrolled after the effective date of the sanction and until CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5.21 **Payment to FQHCs/RHCs**

5.21.1 Beginning with month of service May 2014, HCA will pay to the Contractor a lump sum monthly amount intended to provide funding to supplement the Contractor's payment to each of its contracted Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHC) to ensure that each FQHC/RHC receives its entire, specific encounter rate for each qualifying encounter. This monthly amount to be paid to the Contractor in a lump sum and subsequently disbursed to each FQHC/RHC as directed by HCA is called an enhancement payment.

5.21.1.1 The lump sum payment to the Contractor for its contracted FQHC/RHC will continue to be based on a prior month's client assignments. The total amount of enhancement payment to be made to each Contractor will be based on the Contractor's correct and timely reporting and submission of client assignment roster files to HCA on a monthly basis. For purposes of this section, the "client assignment roster file" is the electronic file submitted monthly by the Contractor to HCA that is intended to identify the FQHC/RHC to which a Managed Care client has been assigned by the Contractor. The client assignment roster file is specific to client assignment and the resulting per-client enhancement payment only, and it is a separate and distinct process from encounter claim submission. It is this per-client enhancement payment, or capitation payment, that is

aggregated by FQHC/RHC and paid to the Contractor for disbursement to the individual FQHC/RHC. The amount due to each FQHC/RHC will be provided to the Contractor by HCA.

5.21.1.1.1 The Contractor shall submit its client assignment roster files to HCA no later than the 15th of the month for the current month of enrollment. Without exception, any client assignment roster file data received after the 15th of the month will be included in the following month's cycle for HCA's payment to the Contractor.

5.21.1.1.2 Incorrectly submitted client assignment roster files and/or data records within the client assignment roster files will not be included in any payment to the Contractor and must be corrected and re-submitted by the Contractor to HCA before payment is made. Corrected client assignment roster files received after the 15th of the current month will be included in the following month's cycle for payment purposes. Retroactive enrollment and disenrollment shall follow the same timeline and procedure and will be processed no differently than client assignment roster files for the current month.

5.21.1.1.3 Using correctly submitted client assignment roster files, HCA will base the total enhancement payment due to the Contractor on the number of successfully loaded client records multiplied by the specific enhancement rate of each contracted FQHC/RHC. Thus, payment due to each Contractor will be the aggregated amount of all capitation payments for each contracted FQHC/RHC

5.21.1.2 HCA will provide the Contractor with the monthly enhancement payment funds separately from the monthly premium payments.

5.21.1.2.1 These supplemental payments will include the load for the two percent (2%) premium tax as shown on Exhibit A-AHFQHC-1 and A-AHRHC-1 of this contract. The premium tax is retained by the Contractor and is not paid to the FQHC/RHC.

5.21.1.2.2 The enhancement payments will be calculated separately and apart from the risk-based capitation payments made to the Contractor by HCA and at no time will the Contractor be at risk for or have any claim to the enhancement payments.

5.21.2 The FQHC/RHC is entitled to its specific, full encounter rate for each qualifying encounter as outlined in the Medicaid State Plan and in accordance with Section 1902(bb) of the Social Security Act (42 USC § 1396a(bb)). The full encounter

rate shall be at least equal to the Prospective Payment System (PPS) rate specific to each FQHC/RHC and applies to FQHC/RHC reimbursed under the Alternative Payment Methodology (APM) rate methodology and to FQHC/RHC reimbursed under the PPS rate methodology. The encounter rates and enhancement rates for each contracted FQHC/RHC will be provided by HCA to the Contractor on a quarterly basis or sooner if any changes or corrections are needed. The rate files will be published to this location (http:/www.hca.wa.gov/medicaid/rbrvs/Pages/fqhc.aspx), according to the following schedule: January 1, April 1, July 1 and October 1. Any changes that occur during the quarter will be included in the next file and will specify the effective date of the change.

5.21.3 To ensure that each FQHC/RHC receives its entire encounter rate for each qualifying encounter, the Contractor shall pay each contracted Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) in one (1) of the three (3) ways described here:

5.21.3.1 The Contractor shall pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC in addition to payment of claims for services made at standard rates paid to the FQHC/RHC by the Contractor.

The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA; or

5.21.3.2 The Contractor shall pay a monthly capitation rate for services and pay the specific monthly enhancement payment amount provided by HCA to the FQHC/RHC.

The Contractor shall ensure the entire amount of the enhancement payment is passed to each FQHC/RHC as prescribed by HCA within thirty (30) calendar days of the Contractor's receipt of the enhancement payment from HCA; or

5.21.3.3 The Contractor shall pay each FQHC/RHC the full encounter rate for each qualifying encounter based upon claim submissions.

If the FQHC or RHC and the Contractor have agreed to have claims for qualified services paid at the full encounter rate, the Contractor is not obligated to pass on the enhancement payments received from HCA to the FQHC/RHC each month. In these cases, HCA will adjust the amount of the monthly enhancement payment to the Contractor so that additional enhancement funds are not paid for the FQHC/RHC already receiving the full encounter rate at the time of service.

5.21.4 HCA will perform reconciliations on at least an annual basis to ensure that each FQHC/RHC has received its full encounter rate from the Contractor for each

qualifying encounter. For purposes of reconciliation, a qualifying encounter will be based on the Medicaid fee-for-service guidelines for FQHC/RHC in effect at the time of the date of service. These guidelines are published by HCA.

5.21.4.1 HCA will work directly with the FQHC/RHC on quantifying global maternity encounters. The Contractor shall maintain its own guidelines on the billing of these services by the FQHC/RHC.

5.21.5 HCA will base reconciliation findings on the Contractor's timely submission of encounter data, as specified in Section 5.11 of this Contract, for all contracted FQHCs/RHCs. Actual payment amounts will be used for each FQHC/RHC reconciliation, except for the FQHCs/RHCs that receive payment from the Contractor under a capitated model. Reconciliation for the FQHCs/RHCs that are capitated will utilize a fee-for-service equivalency methodology.

5.21.6 Upon completion of reconciliation, HCA shall notify the Contractor of underpayments and/or overpayments for each contracted FQHC/RHC.

5.21.6.1 For any underpayment, in which the FQHC/RHC did not receive its full encounter rate for qualifying encounters, HCA shall pay the Contractor the designated amount due to each FQHC/RHC within fifteen (15) days following HCA's notification to the Contractor of reconciliation results. The Contractor shall make these payments to the FQHC/RGC as designated by HCA within the next thirty (30) days.

5.21.6.2 For any overpayments, in which the FQHC/RHC received more than its full encounter rate for qualifying encounters, HCA will deduct the appropriate amount for the affected FQHC/RHC by adjusting future enhancement payments to the Contractor.

5.21.7 The Contractor shall ensure it has sufficiently trained staff to handle calls and/or inquiries from providers regarding the reimbursement process and client assignment.

5.22 Payment of Physician Services for Trauma Care

The Contractor shall pay physician services an enhancement for severe trauma care. If all criteria are met, the trauma enhancement must be at least 275% of the Contractor's standard rate for the service.

5.22.1 To qualify for the trauma care enhancement, a service must meet all of the following criteria:

5.22.1.1 The service must be provided by a physician or clinician;

5.22.1.2 The service must be hospital-based, with a billed place of service 21, 22, 23, 24, 51, 52, or 56;

5.22.1.3 The service must be provided in a Department of Health designated or

recognized trauma service center; and

5.22.1.4 The provider has indicated that the injury severity score (ISS) criteria has been met by billing with modifier ST in any position. The ISS must be:

5.22.1.4.1 Thirteen (13) or greater for clients age 15 and older;

5.22.1.4.2 Nine (9) or greater for clients younger than age 15;

5.22.1.4.3 Zero (0) or greater when the service is provided at a Level I, II, or III trauma service center when the trauma case is received as a transfer from another facility.

5.22.2 Rehabilitation and surgical services provided within six months of the date of an injury that meets all criteria in subsection 5.22.1 may also receive the enhancement rate if all of the following criteria are met:

5.22.2.1 The follow-up procedures are directly related to the qualifying traumatic injury;

5.22.2.2 The follow-up procedures were planned during the initial acute episode of care, i.e. the inpatient stay; and

5.22.2.3 The plan for the follow-up procedure(s) is clearly documented in the medical record of the client's initial hospitalization for the traumatic injury.

5.22.3 Exemptions. The following services are never subject to trauma care enhancements:

5.22.3.1 Laboratory and pathology services; or

5.22.3.2 Technical component only (TC) charges

5.23 Nonpayment for Provider Preventable Conditions

The Contractor shall comply with the requirements of WAC 182-550-1650 related to Adverse Events, hospital-acquired conditions, and present on admission indicators. The Contractor shall comply with the requirements of the version of WAC 182-502-0022, on Provider Preventable Conditions (PPCs) – Payment Policy in place as of January 1, 2015, which replaces WAC 182-550-1650. In complying with these rules, the Contractor will deny or recover payments to healthcare professionals and inpatient hospitals for care related only to the treatment of the consequences of Healthcare Acquired Conditions (HCAC) and Other Provider Preventable Conditions (OPPC), also known as Serious Adverse Events.

5.24 Billing for Services Provided by Residents

The Contractor shall allow teaching physicians to submit claims for primary care services provided by interns and residents under supervision of the teaching physician.

5.25 Payments for Certain Prescription Drugs

5.25.1 HCA will make payments to the Contractor under this Section only if (a) the Legislature, in its 2015 session, specifically appropriates funds to HCA for this purpose as a supplement to HCA's budget for State Fiscal Year 2015; and (b) federal matching funds are available. HCA will notify the Contractor in writing within thirty (30) calendar days of any such legislative appropriation and any such determination of the availability of federal matching funds.

5.25.2 Within thirty (30) calendar days of any such notification, the Contractor will submit to HCA a payment request consisting of sufficient data to account for the Contractor's financial liability for the prescription drugs Sovaldi, Olysio, and Harvoni that the Contractor incurred under this Contract for services provided during the period of January 1, 2014, through December 31, 2014. The Contractor must certify this data as described in section 5.19 of this Contract, Data Certification Requirements.

5.25.3 Within thirty (30) calendar days of receiving the Contractor's data, HCA shall make payments to the Contractor. If the legislative appropriation described in this Subsection is sufficient to cover all payments requested by all Apple Health Managed Care contractors, then HCA's payment to the Contractor will equal one hundred percent (100%) of the Contractor's payment request.

5.25.3.1 HCA will have sole and exclusive authority to determine the percentage of each Contractor's payments that is covered by the Legislature's appropriation. If the total amount of payment requests submitted by all Apple Health Managed Care contractors exceeds the Legislature's appropriation to HCA, then HCA's payment to the Contractor will be a proportion of the Contractor's payment request. (For example, if the Legislature's appropriation equals eighty percent (80%) of the total payments requested, then HCA will pay the Contractor eighty percent (80%) of its payment request.)

6 ACCESS TO CARE AND PROVIDER NETWORK

6.1 Network Capacity

6.1.1 The Contractor shall maintain and monitor an appropriate provider network, supported by written agreements, sufficient to serve enrollees enrolled under this Contract (42 C.F.R. § 438.206(b)(1)).

6.1.2 To the extent necessary to comply with the provider network adequacy and distance standards required under this Contract, the Contractor shall offer contracts to providers in bordering states. The Contractor's provider contracts with providers in bordering states must ensure timely access to necessary care, including inpatient and outpatient services and must coordinate with Oregon and

Idaho providers to explore opportunities for reciprocal arrangements that allow Washington, Oregon, and Idaho border residents to access care when care is appropriate, available, and cost-effective.

6.1.2.1 The Contractor shall provide quarterly status reports to HCA on its contracting activities in border communities and services area. HCA will provide a template for the report.

6.1.3 The Contractor shall provide contracted services through non-participating providers, at a cost to the enrollee that is no greater than if the contracted services were provided by participating providers, if its network of participating providers is insufficient to meet the medical needs of enrollees in a manner consistent with this Contract. The Contractor shall adequately and timely cover these services out of network for as long as the Contractor's network is inadequate to provide them (42 C.F.R. § 438.206(b)(4)). This provision shall not be construed to require the Contractor to cover such services without authorization except as required for emergency services.

6.1.4 The Contractor shall conduct quarterly quality assurance reviews (outreach phone calls, emails) of individual providers within the Contractor's primary care, pediatric and obstetrical provider network. The Contractor may coordinate with other MCOs to conduct these reviews to avoid duplicate contacts to providers. The Contractor shall:

6.1.4.1 Conduct a review of twenty-five percent (25%) of the combined network of primary care, pediatric primary care and obstetrical care providers.

6.1.4.2 Verify contact information, such as address, phone, email, website and fax numbers.

6.1.4.3 Verify open/closed panel status including whether the provider is currently accepting new Apple Health patients and any current or anticipated limitation on the number of Apple Health patients the provider sets.

6.1.4.4 Complete and submit a biannual report that provides a one (1) page narrative summary of the quality assurance review, including next steps as a result of the analysis. HCA will provide a template for the report. The written narrative will include an attached HCA defined file format that documents providers contacted, changes in provider open/closed panel status and changes in contact information as a result of quality assurance reviews. (Due July 15, 2015 and January 15, 2016).

6.1.5 The Contractor must submit documentation assuring adequate capacity and services, including information regarding its maintenance, monitoring and analysis of the network to include full provider network submissions to determine

compliance with the requirements of this Section, at any time upon HCA request or when there has been a change in the Contractor's network or operations that, in the sole judgment of HCA, would affect adequate capacity and/or the Contractor's ability to provide services (42 C.F.R. § 438.207(b & c)).

6.1.5.1 The Contractor shall submit updated provider network information as requested by HCA:

6.1.5.1.1 At the time it enters into a Contract with HCA and within ten (10) business days of HCA's request.

6.1.5.1.2 At any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services, including:

6.1.5.1.2.1 Changes in services, benefits, geographic service area or payments, or;

6.1.5.1.2.2 Enrollment of a new population in the Contractor.

6.1.5.2 This information will be reviewed by HCA for:

6.1.5.2.1 Completeness and accuracy;

6.1.5.2.2 The need for HCA provision of technical assistance;

6.1.5.2.3 Removal of providers who no longer contract with the Contractor; and

6.1.5.2.4 The effect that the change(s) in the provider network will have on the network's compliance with the requirements of this section.

6.1.6 If the Contractor, in HCA's sole opinion, fails to maintain an adequate network of providers in any contracted service area including all critical provider types: Primary Care Providers, Hospitals, Pharmacy, Mental Health, Obstetrician/Gynecologist, and Pediatrician and high volume specialties identified by the Contractor, for two consecutive quarters, and after notification following the first quarter, HCA reserves the right to immediately terminate the Contractor's services for that service area.

6.1.7 The Contractor shall maintain an online provider directory that meets the following requirements:

6.1.7.1 Maintain a link on the front page of the Contractor's website that immediately links members to the Contractor's online, searchable provider directory.

6.1.7.2 Include a list of all clinics; and primary and specialty providers.

6.1.7.3 Include a description of each primary and specialty provider's languages spoken and if appropriate, a brief description of the provider's skills or experiences that would support the cultural or linguistic needs of its members, e.g., "served in Peace Corps, Tanzania, speaks fluent Swahili".

6.1.7.4 Indicates whether each primary and specialty provider, including mental health professionals have open capacity to serve new patients. Limits on capacity for each primary and specialty provider, including mental health professionals.

6.1.7.5 Include a list of hospitals and pharmacies.

6.1.7.6 Update the provider directory: no less than quarterly; upon completion of quarterly quality assurance reviews described in this 6.1.1.4 of this subsection; or whenever there is a change in the Contractor's network that would affect adequate capacity in a service area.

6.2 **Service Delivery Network**

In the maintenance, monitoring and reporting of its network, the Contractor must consider the following (42 C.F.R. § 438.206(b)):

6.2.1 Expected enrollment for each service area in which the Contractor offers services under this Contract.

6.2.2 Adequate access to all services covered under this Contract.

6.2.3 The expected utilization of services, taking into consideration the characteristics and health care needs of the population represented by the Contractor's enrollees and potential enrollees.

6.2.4 The number and types (in terms of training, experience and specialization) of providers required to furnish the contracted services.

6.2.5 The number of network providers who are not accepting new enrollees or who have placed a limit, or given the Contractor notice of the intent to limit their acceptance of enrollees.

6.2.6 The geographic location of providers and enrollees, considering distance, travel time, the means of transportation ordinarily used by enrollees or potential enrollees, and whether the location provides physical access for the Contractor's enrollees with disabilities.

6.2.7 The cultural, racial/ethnic composition and language needs of enrollees.

6.3 Timely Access to Care

The Contractor shall have contracts in place with all subcontractors that meet state standards for access, taking into account the urgency of the need for services (42 C.F.R. § 438.206(b) & (c)(1)(i))). The Contractor shall ensure that:

6.3.1 Network providers offer access comparable to that offered to commercial enrollees or, if the Contractor serves only Medicaid enrollees, comparable to Medicaid fee-for-service (42 C.F.R. § 438.206(b)(1)(iv) & (c)(1)(ii))).

6.3.2 Mechanisms are established to ensure compliance by providers.

6.3.3 Providers are monitored regularly to determine compliance.

6.3.4 Corrective action is initiated and documented if there is a failure to comply.

6.4 Hours of Operation for Network Providers

The Contractor must require that network providers offer hours of operation for enrollees that are no less than the hours of operation offered to any other patient (42 C.F.R. § 438.206(c)(1)(iii)).

6.5 24/7 Availability

The Contractor shall have the following services available on a 24-hour-a-day, seven-day-a-week basis by telephone. These services may be provided directly by the Contractor or may be delegated to subcontractors (42 C.F.R. § 438.206(c)(1)(iii)).

6.5.1 Medical or mental health advice for enrollees from licensed health care professionals.

6.5.2 Triage concerning the emergent, urgent or routine nature of medical and mental health conditions by licensed health care professionals.

6.5.3 Authorization of urgent and emergency services, including emergency care for mental health conditions and services provided outside the Contractor's service area.

6.5.4 The Contractor shall either cover emergency fills without authorization, or guarantee authorization and payment after the fact for any emergency fill dispensed by a contracted pharmacy.

6.6 Customer Service

The Contractor shall provide adequate staff to provide customer service representation at a minimum from 8:00 a.m. to 5:00 p.m., Pacific Standard Time or Daylight Savings Time (depending on the season), Monday through Friday, year round and shall provide customer service on all dates that are recognized as work days for state employees. HCA may authorize exceptions to this requirement if the Contractor provides HCA with written

assurance that its providers will accept enrollment information from HCA. Toll free numbers shall be provided at the expense of the Contractor.

6.6.1 The Contractor shall report by December 1st of each year its scheduled non-business days for the upcoming calendar year.

6.6.2 The Contractor must notify HCA five (5) business days in advance of any non-scheduled closure during scheduled business days, except in the case when advanced notification is not possible due to emergency conditions.

6.6.3 The Contractor and its subcontracted pharmacy benefit manager, provider help desks, authorization lines, and enrollee customer service centers, if any, shall comply with the following customer service performance standards:

6.6.3.1 Telephone abandonment rate – standard is less than 3%.

6.6.3.2 Telephone response time - average speed of answer within 30 seconds.

6.7 Appointment Standards

The Contractor shall comply with appointment standards that are no longer than the following (42 C.F.R. § 438.206(c)(1)(i)):

6.7.1 Transitional healthcare services by a primary care provider shall be available for clinical assessment and care planning within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program.

6.7.2 Transitional healthcare services by a home care nurse or home care registered counselor within seven (7) calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program, if ordered by the enrollee's primary care provider or as part of the discharge plan.

6.7.3 Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or another provider within thirty (30) calendar days. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.

6.7.4 Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within ten (10) calendar days. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.

6.7.5 Urgent, symptomatic office visits shall be available from the enrollee's PCP or another provider within twenty-four (24) hours. An urgent, symptomatic visit is

associated with the presentation of medical signs that require immediate attention, but are not emergent.

6.7.6 Emergency medical care shall be available twenty-four (24) hours per day, seven (7) days per week.

6.7.7 Failure to meet appointment standards may, at the HCA's sole discretion, result in withholding of payments, assignments and/or re-enrollments as described in the Sanctions subsection of this Contract.

6.8 Provider Database

The Contractor shall have, maintain and provide to HCA upon request an up-to-date database of its provider network. In populating its database, the Contractor shall obtain the following information: the identity, location, languages spoken (when this information is supplied by the provider), qualifications, practice restrictions, and availability of all current contracted providers, including specialty providers (42 C.F.R. § 438.242(b)(1)).

6.9 Provider Network - Distance Standards

6.9.1 The Contractor's network of providers shall meet the distance standards in this subsection in every service area. HCA will designate a zip code in a service area as urban or non-urban for purposes of measurement. HCA will provide to the Contractor a list of service areas, zip codes and their designation. The Contractor's ability to receive enrollment and/or assignment is based on the assignment provisions in this Contract:

6.9.2 PCP

6.9.2.1 Urban: 2 within 10 miles.

6.9.2.2 Non-urban: 1 within 25 miles.

6.9.3 Obstetrics

6.9.3.1 Urban: 2 within 10 miles.

6.9.3.2 Non-urban: 1 within 25 miles.

6.9.4 Pediatrician or Family Practice Physician Qualified to Provide Pediatric Services

6.9.4.1 Urban: 2 within 10 miles.

6.9.4.2 Non-urban: 1 within 25 miles.

6.9.5 Hospital

6.9.5.1 Urban / Non-urban: 1 within 25 miles.

6.9.6 Pharmacy

6.9.6.1 Urban: 1 within 10 miles.

6.9.6.2 Non-urban: 1 within 25 miles.

6.9.7 Mental Health Professionals

6.9.7.1 Urban/non-urban: 1 within 25 miles.

6.9.8 HCA may, in its sole discretion, grant exceptions to the distance standards. HCA's approval of an exception shall be in writing. The Contractor shall request an exception in writing and shall provide evidence as HCA may require supporting the request. If the closest provider of the type subject to the standards in this section is beyond the distance standard applicable to the zip code, the distance standard defaults to the distance to that provider. The closest provider may be a provider not participating with the Contractor.

6.10 **Assignment of Enrollees**

6.10.1 HCA has the sole and exclusive right to determine the methodology and procedures by which enrollees are assigned to the Contractor or reassigned to any other Apple Health Managed Care contractors (MCOs).

6.10.2 HCA may adjust the methodology or procedures at any time during the term of this Contract if, in its sole discretion, it determines that any such adjustment would be in the best interests of HCA or the enrollees.

6.10.3 HCA will count New Individuals, Family Connects, and Plan Reconnects as part of an MCO's enrollment in all service areas.

6.10.4 Reassignment of enrollees

6.10.4.1 HCA may, at its sole discretion reassign enrollees to the Contractor and an individual may choose to voluntarily enroll with the Contractor if the Contractor is eligible to receive enrollment in the individual's service area, consistent with this Subsection.

6.10.5 Assignment of New Individuals

6.10.5.1 The number of New Individuals assigned to the Contractor and to all other MCOs depends on (a) the number of MCOs eligible to receive assignments in a service area; (b) the number of New Individuals eligible for assignment in a service area; and (c) the performances of the Contractor and all other MCOs on the Clinical Performance Measures and the Administrative Measure described in this Section.

6.10.5.2 HCA will assign New Individuals to an eligible MCO in the individual's service area. Once assigned, HCA will notify the enrollee of his or her

assignment and provide information on how the individual can change enrollment to another MCO available in the service area, if any. The effective date of enrollment will be consistent with the enrollment provisions of this Contract.

6.10.5.3 If the Contractor was not contracted with HCA for Apple Health Managed Care services in 2014, HCA will not assign any enrollees to the Contractor.

6.10.6 Service area assignment process:

6.10.6.1 HCA, in its sole discretion, shall determine whether the Contractor's provider network meets the required capacity.

6.10.6.1.1 To receive New Individual assignments and voluntary enrollments in a service area, the Contractor must attain a Capacity Threshold as described in this subsection.

6.10.6.1.2 If at any time during the term of this Contract the Contractor's provider network no longer meets the minimum Capacity Threshold in any service area, HCA may, in its sole discretion, reassign all enrollees covered by the Contractor to another MCO in the service area.

6.10.6.1.2.1 Upon HCA's request, the Contractor shall provide a list of current enrollees and their assigned PCP.

6.10.6.1.2.2 The Contractor shall assist HCA in the orderly transition of enrollees to another MCO, consistent with the Care Coordination and Transitional Healthcare Services provisions of this Contract.

6.10.6.1.3 HCA recognizes that a service area may not have available the full complement of critical provider types; therefore, HCA may, at its sole discretion, make exceptions to provide coverage for that service area.

6.10.6.1.4 The levels of service area participation are described in the following table:

Capacity Threshold	**Number of critical provider types meeting capacity**	**Assignment of New Individuals And/Or Voluntary Enrollment**	**Family Connects or Plan Reconnects**
80% or more	6/6	Assignment and voluntary enrollment	Yes

Capacity Threshold	Number of critical provider types meeting capacity	Assignment of New Individuals And/Or Voluntary Enrollment	Family Connects or Plan Reconnects
80% or more	5/6	No assignment; voluntary enrollment only	Yes
60% or above, but below 80%	6/6	No assignment; voluntary enrollment only	Yes
Below 60%.	N/A	No assignment or voluntary enrollment	None

6.10.6.1.5 For mental health professionals only, HCA shall make a temporary exception to the capacity threshold as follows:

6.10.6.1.5.1 The Contractor shall meet a minimum threshold of sixty percent (60%) or more by July 1, 2015. If the Contractor fails to meet the minimum capacity threshold of sixty percent (60%) by July 1, 2015, HCA may not allow assignment of new individuals or voluntary enrollment within any service area not meeting the sixty percent (60%) capacity threshold.

6.10.6.1.5.2 The Contractor shall meet a minimum threshold of eighty percent (80%) or more by December 31, 2015. If the Contractor fails to meet the minimum capacity threshold of eighty percent (80%) by December 31, 2015, HCA may not allow assignment of new individuals or voluntary enrollment within any service area not meeting the eighty percent (80%) capacity threshold.

6.10.6.2 Enrollments for each month covered by this Contract will be set by HCA based on the performances of the Contractor and all other MCOs under the Clinical Performance Measures and the Administrative Measure described in this Section.

6.10.6.3 For enrollment months January 2015 through June 2015:

6.10.6.3.1 HCA will calculate the Contractor's assignment percentages of New Individuals based on a normed and

weighted average of two Clinical Performance measures and one Administrative Measure.

6.10.6.3.2 Clinical Performance Measures: The Contractor's 2014 reported HEDIS® Clinical Performance measures:

6.10.6.3.2.1 Childhood Immunization Combo 2 Status.

6.10.6.3.2.2 Comprehensive diabetes care: retinal eye exam.

6.10.6.3.3 Administrative Measure (Initial Health Screen): The Contractor's performance on the initial health screen for enrollment months July and August 2014.

6.10.6.4 For enrollment months July 2015 through December 2015, HCA will adjust the Contractor's assignment percentage as follows:

6.10.6.4.1 HCA will calculate the Contractor's assignment percentages of New Individuals based on a normed and weighted average of two HEDIS® Clinical Performance measures and one Administrative Measure.

6.10.6.4.2 Clinical Performance Measures: The Contractor's 2014 reported HEDIS® Clinical Performance measures.

6.10.6.4.2.1 Childhood Immunization Combo 2 Status

6.10.6.4.2.2 Comprehensive diabetes care: retinal eye exam.

6.10.6.4.3 Administrative Measure (Initial Health Screen): The Contractor's performance on the initial health screen for enrollment months January and February 2015.

6.10.7 Administrative Measure (Initial Health Screen) calculation:

6.10.7.1 The Contractor shall report its performance on completing Initial Health Screens on all New Individual, Family Connect, and Plan Reconnect enrollees.

6.10.7.2 The Contractor shall calculate its performance on the Initial Health Screens on a monthly basis.

6.10.7.3 To calculate the monthly screening performance:

6.10.7.3.1 The numerator is the total number of New Individuals, Family Connects, and Plan Reconnects that have received an Initial Health Screen.

6.10.7.3.2 The denominator is the total number of New Individuals, Family Connects, and Plan Reconnects.

6.10.7.3.3 The Contractor shall report its screening performance numerator, denominator and rate (expressed as a percentage) according to the following schedule:

Jan-Feb, 2015	**Mar-Apr 2015**	**May-June 2015**	**July-Aug 2015**	**Sept-Oct, 2015**	**Nov-Dec, 2015**	**Jan-Feb 2016**
Nov, Dec report due to HCA Feb 10, 2015	Jan, Feb report due to HCA April 10, 2015	Mar, Apr, report due to HCA June, 10. 2015	May, June report due to HCA August 10, 2015	July, Aug report due to HCA Oct 10, 2015	Sept, Oct report due to HCA Dec 10, 2015	Nov, Dec 2015 report due to HCA Feb 10, 2016

6.10.7.4 The following scenario illustrates possible adjustments based on performance:

Managed Care Organizations	Childhood Immunization Status Combo 2 measure	Comprehensive diabetes care: retinal eye exam	Initial Health Screen Measure	Average	Normed Adjusted Assignment of New Enrollees
Plan 1	80%	46%	43%	56%	21%
Plan 2	80%	52%	25%	52%	19.5%
Plan 3	60%	45%	33%	46%	17.1%
Plan 4	66%	68%	14%	49%	18.4%
Plan 5	80%	72%	41%	64%	24%

6.11 **Distance Standards for High Volume Specialty Care Providers**

The Contractor shall establish, analyze and meet measurable distance standards for high volume specialty adult care providers, subject to HCA approval. At a minimum the Contractor shall establish, analyze and meet distance standards for Cardiologists, Oncologists, Ophthalmologists, Orthopedic Surgeons, General Surgery, Gastroenterologists, Pulmonologists, Neurologists, Endocrinologists, Otolaryngologists, Mental health professionals with prescribing authority and Specialists in Physical Medicine, Rehabilitation. Special considerations will be made for pediatric specialists. The Contractor shall analyze performance against standards at minimum, annually and provide a report to HCA detailing the outcomes of this analysis along with the Contractor's analysis

of Primary Care Providers described in Subsection 6.1.3. Analyses and documentation for the standards shall be available to HCA upon request.

6.12 Standards for the Ratio of Primary Care and Specialty Providers to Enrollees

The Contractor shall establish and meet measurable standards for the ratio of both PCPs and high volume Specialty Care Providers to enrollees. The Contractor shall analyze performance against standards at minimum, annually.

6.13 Access to Specialty Care

6.13.1 The Contractor shall provide all medically necessary specialty care for enrollees in a service area. If an enrollee needs specialty care from a type of specialist who is not available within the Contractor's provider network, the Contractor shall arrange for the necessary services with the nearest qualified specialist outside the Contractor's provider network, who is willing to see the enrollee.

6.13.2 The Contractor shall maintain, and make readily available to providers, up-to-date information on the Contractor's available network of specialty providers and shall provide any required assistance to providers in obtaining timely referral to specialty care.

6.14 Order of Acceptance

6.14.1 The Contractor shall provide care to all enrollees who voluntarily choose the Contractor and all enrollees assigned by HCA.

6.14.2 Enrollees will be accepted in the order in which they apply.

6.14.3 HCA shall enroll all eligible clients with the Contractor of their choice except as provided herein, unless HCA determines, in its sole judgment, that it is in HCA's best interest to withhold or limit enrollment with the Contractor.

6.14.4 HCA may suspend voluntary enrollment and/or assignments in any service area if, in its sole judgment, the Contractor's network is not adequate to meet the requirements of sections 6.9 Provider Network – Distance Standards and 6.10 Assignment of Enrollees . The Contractor shall submit any information HCA requires to make a final decision on the suspension within thirty (30) calendar days of the Contractor's receipt of the request for information.

6.14.5 The Contractor may request in writing that HCA suspend voluntary enrollment and/or assignments in any service area. HCA will approve the temporary suspension when, in the sole judgment of HCA, it is in the best interest of HCA and/or its clients. The Contractor shall submit any information HCA requires to make a final decision on this request.

6.14.6 The Contractor shall accept clients who are enrolled by HCA in accord with this Contract and Chapter182-538 WAC.

6.14.7 No eligible client shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, the existence of a pre-existing physical or mental condition, including pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

6.15 Provider Network Changes

6.15.1 The Contractor shall give HCA a minimum of ninety (90) calendar days' prior written notice, in accord with the Notices provisions of the General Terms and Conditions Section of this Contract, of the loss of a material provider.

6.15.2 The Contractor shall make a good faith effort to provide written notification to enrollees affected by any provider termination within fifteen (15) calendar days after receiving or issuing a provider termination notice (42 C.F.R. § 438.10(f)(5)). Enrollee notices shall have prior approval of HCA. If the Contractor fails to notify affected enrollees of a provider termination at least sixty (60) calendar days prior to the effective date of termination, the Contractor shall allow affected enrollees to continue to receive services from the terminating provider, at the enrollees' option, and administer benefits for the lesser of a period ending the last day of the month in which sixty (60) calendar days elapses from the date the Contractor notifies enrollees or the enrollee's effective date of enrollment with another plan.

6.15.3 HCA reserves the right to reduce the premium to recover any expenses incurred by HCA as a result of the withdrawal of a material subcontractor from a service area. This reimbursable expense shall be in addition to any other provisions of this Contract.

6.15.4 HCA reserves the right to impose Sanctions, in accordance with the Sanctions subsection of this Contract, if the Contractor was notified by the terminating provider in a timely manner and does not comply with the notification requirements of this section.

6.15.4.1 If the Contractor does not receive timely notification from the terminating provider, the Contractor shall provide documentation of the date of notification along with the notice of loss of a material provider.

6.16 Medicaid Enrollment, Non-Billing Providers

The Contractor shall ensure that all of its contracted providers have a signed Core Provider Agreement with HCA within one hundred twenty (120) calendar days of contracting with the Contractor. A provider may enroll with HCA as a “non-billing” provider if he or she does not wish to serve fee-for-service Medicaid clients, but the provider must have an active NPI number with HCA.

6.17 Network Submissions for Washington Healthplanfinder

HCA intends to implement enrollee managed care plan selection (also known as the “Medicaid Shopping Experience”) in the Washington Health Benefit Exchange portal

Healthplanfinder, with an estimated implementation date early in calendar year 2015. The Contractor shall submit and maintain provider network data in *Healthplanfinder* in a format specified by HCA to support enrollee plan selection and submit performance measure data, publically reported such as HEDIS® and CAHPS results, used by consumers to select an Apple Health Managed Care Contractor. HCA will develop a detailed implementation schedule to include specific dates for Contractor submission of information. In addition, the Contractor may be required to participate in testing of provider network functionality. HCA will provide the Contractor with at least sixty (60) days' notice as detailed testing and implementation dates are established.

7 QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT

7.1 Quality Assessment and Performance Improvement (QAPI) Program

7.1.1 The Contractor shall have and maintain a quality assessment and performance improvement (QAPI) program for the physical and behavioral health services it furnishes to its enrollees that meets the provisions of 42 C.F.R. § 438.240.

7.1.1.1 The Contractor shall define its QAPI program structure and processes and assign responsibility to appropriate individuals.

7.1.1.2 The QAPI program structure shall include the following elements:

7.1.1.2.1 A written description of the QAPI program including identification and description of the roles of designated physician and behavioral health practitioners. The QAPI program description shall include:

7.1.1.2.1.1 A listing of all quality-related committee(s);

7.1.1.2.1.2 Descriptions of committee responsibilities;

7.1.1.2.1.3 Contractor staff and practicing provider committee participant titles;

7.1.1.2.1.4 Meeting frequency; and

7.1.1.2.1.5 Maintenance of meeting minutes, signed and dated reflecting decisions made by each committee, as appropriate.

7.1.1.2.2 A Quality Improvement (QI) Committee that oversees the quality functions of the Contractor. The Quality Improvement Committee will:

7.1.1.2.2.1 Recommend policy decisions;

7.1.1.2.2.2 Analyze and evaluate the results of QI activities including annual review of the results of performance measures, utilization data and performance improvement;

7.1.1.2.2.3 Institute actions to address performance deficiencies; and

7.1.1.2.2.4 Ensure appropriate follow-up.

7.1.1.2.3 An annual quality work plan, including objectives for serving individuals with special health care needs and enrollees from diverse communities. The work plan shall contain:

7.1.1.2.3.1 Goals and objectives for the year, including objectives for patient safety, serving a culturally and linguistically diverse membership and individuals with special health care needs;

7.1.1.2.3.2 Timeframe to complete each activity;

7.1.1.2.3.3 Identification of a responsible person for each activity; and

7.1.1.2.3.4 Monitoring plans to assure implementation of the work plan, including at least quarterly documentation of the status of said goals and objectives.

7.1.1.2.4 An annual written report of the overall evaluation of the effectiveness of the Contractor QAPI program. (42 C.F.R. § 438.240(e)(2)). The report shall include at minimum:

7.1.1.2.4.1 HEDIS and non-HEDIS contractually required performance measure and utilization data pictorially displayed using charts and graphs, trended over time and compared against the Medicaid National Committee for Quality Assurance 75th or 25th percentile for performance or other comparable, published Benchmarks.

7.1.1.2.4.2 Accompanying written analysis of performance, including data comparisons to national and/or other benchmarks.

7.1.1.2.4.3 Interventions undertaken and/or planned during the past or future review period to address underutilization, overutilization or mis-utilization patterns.

7.1.1.2.4.4 An evaluation of the impact of interventions, including any planned follow-up actions or interventions.

7.1.1.2.4.5 A written assessment of the success of contractually required performance improvement projects.

7.1.2 Upon request, the Contractor shall make available to providers, enrollees, or the HCA, the QAPI program description, and information on the Contractor's progress towards meeting its quality plans and goals.

7.1.3 The Contractor shall provide evidence of oversight of delegated entities responsible for quality improvement. Oversight activities shall include evidence of:

7.1.3.1 A delegation agreement with each delegated entity describing the responsibilities of the Contractor and delegated entity.

7.1.3.2 Evaluation of the delegated organization prior to delegation.

7.1.3.3 An annual evaluation of the delegated entity.

7.1.3.4 Evaluation of regular delegated entity reports.

7.1.3.5 Follow-up on issues out of compliance with delegated agreement or HCA contract specifications.

7.2 **Performance Improvement Projects**

7.2.1 The Contractor shall have an ongoing program of performance improvement projects (PIPs) that focus on clinical and non-clinical areas. The Contractor shall conduct the following PIPs:

7.2.1.1 One clinical PIP piloting a mental health intervention that is evidence-based, research-based or a promising practice and is recognized by the Washington State Institute for Public Policy: WSIPP Reports;

7.2.1.2 Additional clinical PIPs if the Contractor's HEDIS® rates are below the contractually required benchmarks described in this Contract;

7.2.1.3 One non-clinical PIP, conducted in partnership between the Department of Health and the Contractor, which will be a statewide PIP on Transitional Healthcare Services described in this Contract; and

7.2.1.4 One non-clinical PIP conducted in partnership with HCA related to the Clinical Data Repository as described in this Section.

7.2.2 The PIPs must be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Through implementation of performance improvement projects, the Contractor shall:

7.2.2.1 Measure performance using objective quality indicators.

7.2.2.2 Implement system interventions to achieve improvement in quality.

7.2.2.3 Evaluate the effectiveness of the interventions.

7.2.2.4 Plan and initiate activities for increasing or sustaining improvement.

7.2.2.5 Report the status and results of each project to HCA (42 C.F.R. § 438.240(d)(2)).

7.2.2.6 Complete projects in a reasonable time period as to allow aggregate information on the success of the projects to produce new information on the quality of care every year (42 C.F.R. § 438.240(d)(2)).

7.2.3 Annually, the Contractor shall submit to HCA all required clinical and non-clinical performance improvement projects. Each project shall be documented on a performance improvement project worksheet found in the CMS protocol entitled "Conducting Performance Improvement Projects".

7.2.4 If any of the Contractor's 2014 reported Healthcare Effectiveness Data and Information Set (HEDIS®) rates on Childhood Immunizations and Well Child Visits fall below the HCA target goals described in this subsection, the Contractor shall implement clinical PIP(s) designed to increase rates. The benchmarks are:

7.2.4.1 Childhood Immunizations, Combo 2 – achieve, at minimum 68 percent.

7.2.4.2 Well child visits in the first fifteen (15) months, six or more well-child visits – achieve, at minimum 60 percent.

7.2.4.3 Well child visits in the third (3rd), fourth (4th), fifth (5th) and sixth (6th) years of life – achieve, at minimum 68 percent.

7.2.4.4 Adolescent Well Care Visits – achieve, at minimum 43 percent.

7.2.5 The Contractor shall collaborate with peer Medicaid managed care organizations and DOH to conduct one non-clinical statewide PIP on Transitional Healthcare Services (THS) focused on individuals with special health care needs or at risk for re-institutionalization, re-hospitalization, or substance use disorder recidivism.

The Contractor will collaborate with peer Medicaid managed care organizations, primary care providers, regional support networks, state institutions, long-term care providers, hospitals, and substance use disorder programs to plan, execute and evaluate the project. The project shall include the following work:

7.2.5.1 Appointment of a leader to manage the PIP including development of a project plan, budget, intervention activities and a plan for evaluating the impact of the PIP.

7.2.5.2 Commitment of all peer Medicaid managed care organizations, including the Contractor, to collectively provide adequate funding, resources and staff to plan, execute and evaluate the PIP.

7.2.5.3 Coordinate with existing state efforts to improve care transitions such as projects led by the Washington State Hospital Association, Qualis Health, and grantees of the Community-based Care Transitions Program.

7.2.5.4 Participate in a planning group organized by the Washington Department of Health and a group leader in collaboration with all team members.

7.2.5.5 Define the target populations and scope of the PIP.

7.2.5.6 Define intervention(s) used in the PIP.

7.2.5.7 Evaluate the success of interventions at reducing re-institutionalization, re-hospitalization, or substance use disorder relapses. Interventions targeted at these outcomes will be prioritized for action by the Medicaid managed care organizations, including the Contractor.

7.2.5.8 Quarterly progress reports providing an update on the status of the Transitional Healthcare Services PIP shall be submitted by the Project Leader to HCA beginning the first Monday in January 2015 and quarterly thereafter on the following dates: April 15, 2015; July 15, 2015; and October 15, 2015.

7.2.5.9 The Contractor and peer Medicaid managed care organizations shall submit a PIP reporting form to HCA annually, including measures of effectiveness.

7.2.5.10 The Contractor shall provide financial support to the Department of Health (DOH) to conduct the ongoing Transitions PIP and training in the following manner:

7.2.5.10.1 The Contractor shall make semi-annual payments, due to DOH on June 30, 2015 and December 31, 2015 based on MCO enrollment on December 1, 2014. If the

Contractor was not contracted with HCA for Apple Health Managed Care services in 2014, the Contractor shall pay DOH fifty percent of the amount shown in this subsection, based on its June 2015 enrollment. This payment is due to DOH on December 31, 2015.

7.2.5.10.1.1 If the Contractor's enrollment is less than 25,000, the Contractor shall make two payments of $25,000 each to support the PIP.

7.2.5.10.1.2 If the Contractor's enrollment is 25,000 or more but less than 100,000, the Contractor shall make two payments of $37,500 each to support the PIP.

7.2.5.10.1.3 If the Contractor's enrollment is 100,000 or greater, the Contractor shall make two payments of $75,000 each to support the PIP.

7.2.6 Integrated Patient Record/Clinical Data Repository - Non-clinical Performance Improvement Project.

The Contractor shall collaborate with peer MCOs, HCA, and the State HIE to conduct a multi-year non-clinical statewide Performance Improvement Project (PIP) to establish and maintain a longitudinal integrated patient record for Apple Health enrollees assigned to Contractor.

The integrated patient record will be housed in a Clinical Data Repository (CDR) using a service provided by the State HIE and set up by HCA. HCA will invest in the technical infrastructure necessary to set up, prepare and source the CDR with patient demographic and other relevant administrative data for all Apple Health Enrollees.

The integrated patient record will bring physical, dental and behavioral health data currently stored in disparate provider EHR systems and other state and local data sources across the health care delivery system together.

The CDR will connect and leverage the power of information and federal, state, and private investments in EHR technology to enable care coordination and increased communication among providers across multiple disciplines and organizations. This effort will provide access to data sets that are not broadly available to authorized clinicians, care teams, communities, plans and purchasers that can be used to improve care.

7.2.6.1 The Contractor shall appoint a representative to provide input into the CDR project plan, and an evaluation of the PIP.

7.2.6.2 The Contractor shall pay the operational cost of $1.05 per year to maintain an integrated health record for each AH enrollee.

7.2.6.2.1 Using the HIPPA 834 monthly audit files, the Contractor's total enrollment for January 2015 and July 2015 will be reported to the State HIE by HCA.

7.2.6.2.2 The State HIE will bill the Contractor for the maintenance of their enrollees' integrated health records in two installments with estimated due dates of January 31, 2015 and July 1, 2015.

7.2.6.2.3 The Contractor shall pay the State HIE in full by the due date indicated on the billings.

7.2.6.2.4 If the Contractor fails to pay the State HIE within thirty (30) days of the due date on the billing, HCA will withhold the amount due from the next available scheduled monthly AH premium payment to the Contractor.

7.2.6.2.5 Costs to the Contractor to connect to the HIE to access data are the responsibility of the Contractor.

7.2.6.2.6 Costs to the subcontractors to program EHR systems or connect to the HIE are the responsibility of individual entities.

7.2.6.2.7 The HCA shall select subcontractors to be involved in the PIP by January 1, 2015 who are known to have certified EHR systems and are most ready and able to export a standard C-CDA transaction via the HIE each time an Apple Health managed Care enrollee is seen.

7.2.6.2.8 The Contractor shall coordinate with HCA and the State HIE state efforts to facilitate readiness activities intended to prepare for the secure exchange of high value health information among subcontractors with certified EHR systems identified as early adopters by HCA through participation in communication and readiness activities organized by HCA and HIE. The Contractor shall reinforce state expectations that subcontracted providers with certified EHR systems begin ongoing submission of automated exports of standard CCD/CCDA from their EHR to the CDR via the HIE each time an Apple Health Managed Care enrollee is seen by July 1, 2016. The Contractor will

include contract language during the next round of contract activities with subcontractors.

7.2.6.2.9 The Contractor shall participate in an analysis of impact on using data within the CDR to measure performance when available instead of traditional methods of collecting the data manually through chart reviews. Data sets may include but are not limited to Body Mass Index, blood pressure, laboratory results, and clinical screenings.

7.3 Performance Measures using Healthcare Effectiveness Data & Information Set (HEDIS®) and Non-HEDIS Measures®

7.3.1 In accord with the Notices provisions of the General Terms and Conditions Section of this Contract, the Contractor shall report to HCA HEDIS® measures using the current HEDIS® Technical Specifications and official corrections published by NCQA, unless directed otherwise in writing by HCA. For the HEDIS® measures listed below, the Contractor shall use the administrative or hybrid data collection methods, specified in the current HEDIS® Technical Specifications, unless directed otherwise by HCA (42 C.F.R. § 438.240(b)(2)). The Contractor shall make its best effort to maximize data collection.

7.3.2 In addition, the Contractor shall collect and report the non-HEDIS® measures, identified as such, following specifications provided by HCA.

7.3.3 No later than June 15 of each year, HEDIS® and non- HEDIS® measures shall be submitted electronically to HCA using the NCQA Interactive Data Submission System (IDSS) or other NCQA-approved method and methods provided by HCA to the Contractor for non- HEDIS® measures.

7.3.4 The following HEDIS® and non-HEDIS® measures shall be submitted to HCA in reporting year 2015; for the data collection period January 1, 2014 through December 31, 2014.

7.3.4.1 Childhood Immunization Status

7.3.4.2 Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents

7.3.4.3 Adult(s) Access to Preventive/Ambulatory Health Services

7.3.4.4 Adult BMI Assessment

7.3.4.5 Children and Adolescents' Access to Primary Care Practitioners

7.3.4.6 Well Child Visits in the First 15 Months of Life

7.3.4.7 Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

7.3.4.8 Adolescent Well-Care Visits

7.3.4.9 Prenatal and Post-Partum Care

7.3.4.10 Diabetes Screening For Individuals With Schizophrenia Or Bipolar Disorder Who Are Using Antipsychotic Medications

7.3.4.11 Diabetes Monitoring For Individuals With Diabetes and Schizophrenia

7.3.4.12 Cardiovascular Monitoring For Individuals With Cardiovascular Disease and Schizophrenia

7.3.4.13 Adherence to Antipsychotic Medications By Individuals With Schizophrenia

7.3.4.14 Medical Assistance With Smoking and Tobacco Use Cessation

7.3.4.15 Preventive Care and Screening: Tobacco Use Screening and Cessation Intervention (NQF 0028)

7.3.4.16 Preventive Care and Screening: Screening For Clinical Depression and Follow-Up Plan

7.3.4.17 Ambulatory Care Sensitive Condition Hospital Admissions (Diabetes Short-Term Complications, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Asthma) - AHRQ-PQI Measures

7.3.4.18 Plan All-Cause Readmission

7.3.4.19 Inpatient Utilization – General Hospital/Acute Care

7.3.4.20 Ambulatory Care (Outpatient and Emergency Department visits)

7.3.4.21 Mental Health Utilization – Outpatient or ED measure

7.3.4.22 Comprehensive Diabetes Care

7.3.4.23 All NCQA required HEDIS® measures not otherwise specified in this Section.

7.3.5 The Contractor shall submit raw de-identified HEDIS® and non- HEDIS® data to HCA electronically for all measures, no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data according to specifications provided by HCA.

7.3.6 All HEDIS® and non- HEDIS® measures including the CAHPS® sample frame, shall be audited by a designated certified HEDIS® Compliance Auditor, a

licensed organization in accord with methods described in the current HEDIS® Compliance Audit™ Standards, Policies and Procedures and the Centers for Medicare and Medicaid (CMS) Validating Performance Measures Protocol found at http://www.cms.hhs.gov/MedicaidSCHIPQualPrac/ for non-HEDIS® measures. HCA will fund and the designated EQRO will conduct the audit.

7.3.7 The Contractor shall cooperate with HCA's designated EQRO to validate the Contractor's Healthcare Effectiveness Data and Information Set (HEDIS®) performance measures and CAHPS® sample frame.

7.3.7.1 If the Contractor does not have NCQA accreditation for its Medicaid/CHIP product from the National Committee for Quality Assurance (NCQA), the Contractor shall receive a partial audit.

7.3.7.2 If the Contractor has NCQA accreditation for its Medicaid/CHIP product or is seeking accreditation with a scheduled NCQA visit during the Contract term, the Contractor shall receive a full audit.

7.3.7.3 Data collected and the methods employed for HEDIS® validation may be supplemented by indicators and/or processes published in the Centers for Medicare and Medicaid (CMS) Validating Performance Measures protocol identified by HCA designated EQRO.

7.3.8 The Contractor shall provide evidence of trending of measures to assess performance in quality and safety of clinical care and quality of non-clinical or service-related care.

7.3.9 The Contractor shall collect and maintain data on ethnicity, race and language markers as established by HCA on all enrollees. The Contractor shall record and maintain enrollee self-identified data as established by the Contractor and maintain unique data fields for self-identified data.

7.3.10 The Contractor, in collaboration with peer managed care organizations, shall disaggregate data on at least one preventive care measure and examine the data for racial/ethnic disparities and in collaboration with peer managed care organizations, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on future preventive care utilization patterns.

7.3.11 The Contractor shall rotate HEDIS® measures only with HCA's advance written approval. The Contractor may request approval to rotate measures by making a written request to the HCA contact named in the Notices provision of the General Terms and Conditions of this Contract. Childhood Immunization and well-child measures may not be rotated.

7.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

7.4.1 In 2015, the Contractor shall conduct the CAHPS® Child and Child with Chronic Conditions survey for AH enrollees.

7.4.1.1 The Contractor shall contract with an NCQA-certified HEDIS® survey vendor qualified to administer the CAHPS® survey and conduct the survey according to NCQA protocol. The Contractor shall submit the following information to the HCA designated EQRO:

7.4.1.1.1 Contractor CAHPS® survey staff member contact, CAHPS® vendor name and CAHPS® primary vendor contact by January 9, 2015.

7.4.1.1.2 Timeline for implementation of vendor tasks by January 16, 2015.

7.4.1.2 The Contractor shall ensure the survey sample frame consists of all child plan members 17 (seventeen) years and younger with Washington State addresses. In administering the CAHPS® the Contractor shall:

7.4.1.2.1 Submit the eligible sample frame file(s) for certification by the HCA designated EQRO, a Certified HEDIS Auditor by second Friday in January 16, 2015.

7.4.1.2.2 Receive written notice of the sample frame file(s) compliance audit certification from the HCA designated EQRO by January 30, 2015.

7.4.1.2.3 Receive the approved HCA questionnaire by January 9, 2015. HCA EQRO shall determine the questionnaire format, questions and question placement, using the most recent HEDIS® version of the Medicaid child and child with chronic conditions questionnaire (currently 5.0H), plus approved supplemental and/or custom questions as determined by HCA.

7.4.1.2.4 HCA will add twenty (20) supplemental questions to the Contractor's survey. These questions will encompass 15 questions from the World Health Organization Quality of Life (known as WHOQOL-BREF): Physical Health Scale (7 questions), Emotional Health Scale (6 questions), and Overall Quality of Life Scale (2 questions). Another 5 questions are to be determined and will target children with mental health conditions.

7.4.1.2.5 Conduct the mixed methodology (two questionnaires and two reminder postcards with telephone follow-up of at least three telephone attempts) for CAHPS® survey administration.

7.4.1.2.6 Submit the final sample disposition report by June 19, 2015.

7.4.1.2.7 Submit a copy of the Washington State child and child with chronic conditions Medicaid response data set according to 2015 NCQA/CAHPS® standards to the HCA designated EQRO by June 19, 2015.

7.4.1.3 The HCA requires the Contractor to submit its 2015 CAHPS data to the National CAHPS Benchmarking Database (NCBD) by the submission deadline set by the CAHPS Database.

7.4.1.3.1 The Contractor shall submit the NCBD vendor submission information to the HCA designated EQRO by April 10, 2015, or the earliest date available.

7.4.1.3.2 The HCA designated EQRO shall submit the data to the NCBD.

7.4.2 The Contractor shall submit its CAHPS data, deidentified to the HCA no later than June 30 of each year. The Contractor shall submit the raw HEDIS® data according to specifications provided by HCA.

7.4.3 The Contractor shall notify HCA in writing if the Contractor cannot conduct the CAHPS® survey because of limited total enrollment and/or sample size. The written statement shall provide enrollment and/or sample size data to support the Contractor's inability to meet the requirement.

7.5 NCQA Accreditation

7.5.1 The Contractor shall have NCQA accreditation at a level of "accredited" or better by December 31, 2015.

7.5.2 If the Contractor was contracted with HCA to provide Apple Health Managed Care services in 2014, the Contractor shall notify HCA of the date of its NCQA site visit by January 31, 2015 or within fifteen (15) days of confirmation of the site visit by NCQA. The Contractor shall provide HCA with all written materials submitted to NCQA for purposes of the NCQA audit and allow HCA representative(s) to participate in the NCQA audit activities, including the site visit.

7.5.3 Achievement of provisional accreditation status shall require a corrective action plan within thirty (30) calendar days of receipt of the final NCQA report and may result in termination of the contract in accordance with the terms and conditions set forth in this Contract.

7.5.4 If the Contract was not contracted with HCA for Apple Health Managed Care services in 2014, it shall obtain NCQA accreditation at a level of "accredited" or better within eighteen (18) months of the effective date of this Contract, but no later than thirty (30) months following the effective date of this Contract. The Contractor shall file its application within ninety (90) days of the effective date of this Contract.

7.5.5 If the Contractor fails to obtain accreditation at a level of "accredited" or better within the timeframe described in this subsection or if the Contractor fails to maintain accreditation thereafter, the Contractor shall be considered in breach of this Contract. HCA shall terminate the Contract in accordance with the Termination by Default Subsection of this Contract.

7.6 External Quality Review

7.6.1 Validation Activities: The Contractor's quality program shall be examined using a series of required validation procedures. The examination shall be implemented and conducted by HCA, its agent, or an EQRO.

7.6.2 The following required activities will be validated (42 C.F.R. § 438.358(b)(1)(2)(3)):

7.6.2.1 Performance improvement projects.

7.6.2.2 Performance measures.

7.6.2.3 A monitoring review of standards established by HCA and included in this Contract to comply with 42 C.F.R. § 438.204 (g) and a comprehensive review conducted within the previous three-year period.

7.6.3 HCA reserves the right to include additional optional activities described in 42 C.F.R. § 438.358 if additional funding becomes available and as mutually negotiated between HCA and the Contractor.

7.6.4 The Contractor shall submit reports, findings, and other results obtained from a Medicare or private accreditation review (e.g., CMS, NCQA, EValue8, URAC, etc.) if requested by HCA. HCA may, at its sole option, use the accreditation review results in lieu of an assessment of compliance with any Federal or State standards and the review conducted by HCA of those standards.

7.6.5 The Contractor shall submit to annual HCA and EQRO monitoring reviews. The monitoring review process uses standards developed by HCA and methods and data collection tools and methods found in the CMS EQR Managed Care Organization Protocol and assesses the Contractor's compliance with regulatory requirements and standards of the quality outcomes and timeliness of, and access to, services provided by Medicaid MCOs (42 C.F.R. § 438.204).

7.6.6 The Contractor shall, during an HCA annual monitoring review of the Contractor's compliance with Contract standards or upon request by HCA or its External Quality Review Organization (EQRO) Contractor(s), provide evidence of how external quality review findings, agency audits and Contract monitoring activities, enrollee grievances, HEDIS® and CAHPS® results are used to identify and correct problems and to improve care and services to enrollees.

7.6.7 The Contractor will provide data requested by the EQRO for purposes of completing the External Quality Review Report (EQRR). The EQRR is a detailed technical report that describes the manner in which the data from all activities described in External Quality Review provisions of this Section and conducted in accord with C.F.R. § 42 438.358 were aggregated and analyzed and conclusions drawn as to the quality, timeliness and access to the care furnished by the Contractor.

7.6.8 HCA will provide a copy of the EQRR to the Contractor, through print or electronic media and to interested parties such as participating health care providers, enrollees and potential enrollees of the Contractor, enrollee advocacy groups, and members of the general public. HCA must make this information available in alternative formats for persons with sensory impairments, when requested.

7.6.9 If the Contractor has had an accreditation review or visit by NCQA or another accrediting body, the Contractor shall provide the complete report from that organization to HCA. If permitted by the accrediting body, the Contractor shall allow a state representative to accompany any accreditation review team during the site visit in an official observer status. The state representative shall be allowed to share information with HCA and Washington Department of Health (DOH) as needed to reduce duplicated work for both the Contractor and the state.

7.6.10 The Contractor shall submit an annual update to the HCA as part of the annual monitoring review, or as required by the HCA about currently held Medicare Contracts in the State of Washington, including county-level coverage information under part C of title XVIII or under section 1876 of the Act.

7.7 Enrollee Mortality

The Contractor shall maintain a record of known enrollee deaths, including the enrollee's name, date of birth, age at death, location of death, and cause(s) of death. This information shall be available to HCA upon request within ten (10) business days. The Contractor shall assist HCA in efforts to evaluate and improve the availability and utility of selected mortality information for quality improvement purposes.

7.8 Critical Incident Reporting

The Contractor shall notify HCA of any critical incident of which it becomes aware as described in this Subsection:

7.8.1 Examples of incidents to report include but are not limited to: homicide, attempted homicide, completed suicide, attempted suicide, the unexpected death of an enrollee, or abuse, neglect, or exploitation of an enrollee by an employee or volunteer.

7.8.2 Notification must be made to the HCA-designated Contract Manager during the

business day in which the Contractor becomes aware of such an event. If the Contractor becomes aware of the event after business hours, notice must be given as soon as possible during the next business day.

7.8.3 Notification must include a description of the event.

7.8.4 When requested by HCA, the Contractor shall submit a written report within two weeks of the original notification to provide information regarding any actions taken in response to the incident, the purpose for which any action was taken, any implications to the service delivery system, and efforts designed to prevent or lessen the possibility of future similar incidents.

7.9 **Practice Guidelines**

7.9.1 The Contractor shall adopt physical and behavioral health practice guidelines known to be effective in improving health outcomes. Practice guidelines shall meet the following requirements (42 C.F.R. § 438.236):

7.9.1.1 Are based upon the following:

7.9.1.1.1 Valid and reliable clinical scientific evidence;

7.9.1.1.2 In the absence of scientific evidence, on professional standards; or

7.9.1.1.3 In the absence of both scientific evidence and professional standards, a consensus of health care professionals in the particular field.

7.9.1.2 When possible, the Contractor shall develop guidelines based on the United States Preventive Services Task Force (USPSTF) as the primary source. The Contractor may adopt guidelines developed by recognized sources that develop or promote evidence-based clinical practice guidelines such as voluntary health organizations, or National Institute of Health Centers and Institutes. If the Contractor does not adopt guidelines from recognized sources, board-certified practitioners must participate in the development of the guidelines.

7.9.1.3 Consider the needs of enrollees and support client and family involvement in care plans.

7.9.1.4 Are adopted in consultation with contracting health care professionals within the State of Washington.

7.9.1.5 Are reviewed and updated at least every two years and more often if national guidelines change during that time.

7.9.1.6 Are disseminated to all affected providers and, upon request, to HCA, enrollees and potential enrollees (42 C.F.R. § 438.236(c)).

7.9.1.7 Are distributed to affected providers within sixty (60) calendar days of adoption or revision, identifying which specific guidelines are newly adopted or revised. Are distributed to new providers. If distributed via the Internet, notification of the availability of adopted or revised guidelines must be provided to providers. If the Contractor uses fax or e-mail to disseminate the guidelines, it must use an alternative method for those providers that do not have fax or e-mail access.

7.9.1.8 The Contractor must maintain a record of notification, including dates, method of distribution, and which guidelines were affected.

7.9.1.9 Are the basis for and are consistent with decisions for utilization management, enrollee education, coverage of services, and other areas to which the guidelines apply (42 C.F.R. § 438.236(d)).

7.9.2 The Contractor shall develop health promotion and preventive care educational materials for enrollees using both print and electronic media. In developing these materials, the Contractor shall:

7.9.2.1 Conduct outreach to enrollees to promote timely access to preventive care according to Contractor-established preventive care guidelines.

7.9.2.2 Report on preventive care utilization through required performance measure reporting.

7.9.2.3 In collaboration with peer managed care organizations, disaggregate data on at least one preventive care measure and examine the data for racial/ethnic disparities.

7.9.2.4 In collaboration with peer managed care organizations, target interventions with known disparities in preventive care utilization and measure the impact of the interventions on utilization patterns.

7.10 **Drug Formulary Requirements**

The Contractor shall submit its drug formulary to HCA for review and approval.

7.10.1 The term “Formulary” as used in this subsection includes lists of products and their formulary status, authorization requirements and coverage limitations available through retail specialty, and mail order pharmacies, and drugs paid by the Contractor under the medical benefits.

7.10.2 The Contractor shall maintain an HCA-approved formulary that includes the following:

7.10.2.1 All therapeutic classes in the HCA’s fee-for-service drug file and a variety of drugs in each therapeutic class determined by HCA to be sufficient to meet enrollees’ medically necessary health care needs.

7.10.2.2 A number of drugs in each US Pharmacopeia (USP) category and

class equal to or greater than the number included in Washington State's selected Essential Health Benefit (EHB) benchmark plan

7.10.2.3 At least one drug in any USP category and class for which the EHB benchmark plan has no covered drugs

7.10.2.4 Additional drugs as determined necessary by HCA to meet enrollees' medically necessary health care needs

7.10.2.5 Atypical and conventional antipsychotic medications identical to coverage provided under HCA's Medicaid fee-for-service benefit, including indefinite continuation of therapy for any medication an enrollee has been previously prescribed

7.10.2.6 All drugs with FDA-approved indications for treatment of substance use disorders according to coverage guidelines provided by HCA.

7.10.3 Formulary submission and approval

7.10.3.1 The Contractor shall submit its drug formulary and related material to HCA for review and approval no later than September 2, 2015, in an electronic format according to HCA specifications via secure e-mail to hcamcprograms@hca.wa.gov for approval for the 2016 benefit year.

7.10.3.2 If HCA determines the Contractor's formulary does not contain a sufficient variety of drugs in each therapeutic class, the Contractor shall amend and update its formulary and related materials as required by HCA.

7.10.3.3 Upon request by HCA, the Contractor shall submit any additional materials required to determine the sufficiency of the formulary within five (5) business days of the request.

7.10.3.4 HCA shall notify the Contractor of either the approval of its formulary or any required changes, no later than November 1, 2015. Once approved, any change to the formulary must be approved by HCA before the change becomes effective.

7.10.3.5 If HCA notifies the Contractor of required changes, all such changes must be completed and resubmitted no later than December 1, 2015.

7.10.3.6 After final approval of the Contractor's formulary by HCA, the Contractor shall prominently display its formulary, coverage criteria, and information on how to request a nonformulary drug online for members, participating pharmacies and participating providers.

7.10.3.7 HCA may require changes to the Contractor's formulary after initial approval. HCA shall give the Contractor sixty (60) calendar days'

notice of any required change. Failure to make requested changes by the date specified by HCA may result in sanctions as described in the Sanctions Subsection of this Contract.

7.11 Health Information Systems

The Contractor shall maintain, and shall require subcontractors to maintain, a health information system that complies with the requirements of 42 C.F.R. § 438.242 and provides the information necessary to meet the Contractor's obligations under this Contract. The Contractor shall have in place mechanisms to verify the health information received from subcontractors. The health information system must:

7.11.1 Collect, analyze, integrate, and report data. The system must provide information on areas including but not limited to, utilization, grievance and appeals, and terminations of enrollment for other than loss of Medicaid eligibility.

7.11.2 Ensure data received from providers is accurate and complete by:

7.11.2.1 Verifying the accuracy and timeliness of reported data;

7.11.2.2 Screening the data for completeness, logic, and consistency; and

7.11.2.3 Collecting service information on standardized formats to the extent feasible and appropriate.

7.11.3 The Contractor shall make all collected data available to HCA and the Center for Medicare and Medicaid Services (CMS) upon request.

7.12 Technical Assistance

The Contractor may request technical assistance for any matter pertaining to this Contract by contacting HCA.

8 POLICIES AND PROCEDURES

The Contractor shall develop, implement, maintain, comply with and monitor compliance with written policies and procedures related to all requirements of this Contract. The Contractor shall submit policies and procedures to the HCA for review and approval in accordance with 8.2 of this Section, Assessment of Policies and Procedures.

8.1 The Contractor's policies and procedures shall:

8.1.1 Direct and guide the Contractor's employees, subcontractors, and any non-contracted providers' compliance with all applicable federal, state, and contractual requirements.

8.1.2 Fully articulate the Contractor's understanding of the requirements.

8.1.3 Have an effective training plan related to the requirements and maintain records of the number of staff participating in training, including evidence of assessment

of participant knowledge and satisfaction with the training.

8.1.4 Have an effective training plan related to the requirements and maintain records of the number of providers who participate in training, including satisfaction with the training.

8.1.5 Include monitoring of compliance, prompt response to detected non-compliance, and effective corrective action.

8.2 Assessment of Policies and Procedures

The Contractor shall complete a self-assessment of its policies and procedures related to this Contract to HCA for review and approval. The self-assessment will be developed by HCA. The Contractor shall complete and submit the self-assessment no later than June 30, 2014 and, thereafter, in response to corrective action and any time there is a new policy and procedure or a change to an existing policy and procedure. The Contractor shall also submit copies of policies and procedures upon request by HCA.

9 SUBCONTRACTS

9.1 Contractor Remains Legally Responsible

Subcontracts, as defined herein, may be used by the Contractor for the provision of any service under this Contract. However, no subcontract shall terminate the Contractor's legal responsibility to HCA for any work performed under this Contract nor for oversight of any functions and/or responsibilities it delegates to any subcontractor (42 C.F.R. § 434.6 (c) & 438.230(a)).

9.2 Solvency Requirements for Subcontractors

For any subcontractor at financial risk, as defined in the Substantial Financial Risk provision, or of the Risk provision found in the Definitions Section of this Contract, the Contractor shall establish, enforce and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

9.3 Provider Nondiscrimination

9.3.1 The Contractor shall not discriminate, with respect to participation, reimbursement, or indemnification, against providers practicing within their licensed scope of practice solely on the basis of the type of license or certification they hold (42 C.F.R. § 438.12(a)(1)).

9.3.2 If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for its decision (42 C.F.R. § 438.12(a)(1)).

9.3.3 The Contractor’s policies and procedures on provider selection and retention shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment (42 C.F.R. 438.214(c)).

9.3.4 Consistent with the Contractor's responsibilities to the enrollees, this Section may not be construed to require the Contractor to:

9.3.4.1 Contract with providers beyond the number necessary to meet the needs of its enrollees.

9.3.4.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different providers in the same specialty.

9.3.4.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs (42 C.F.R. § 438.12(b)(1)).

9.4 **Required Provisions**

Subcontracts shall be in writing, consistent with the provisions of 42 C.F.R. § 434.6. All subcontracts shall contain the following provisions, in addition to applicable provisions contained in Subsections 9.5 and 9.6 of this Contract:

9.4.1 Identification of the parties of the subcontract and their legal basis for operation in the State of Washington.

9.4.2 The Contractor must monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the HCA, consistent with industry standards or State law and regulation.

9.4.3 Procedures and specific criteria for terminating the subcontract.

9.4.4 Identification of the services to be performed by the subcontractor and which of those services may be subcontracted by the subcontractor. If the Contractor allows the subcontractor to further subcontract, all subcontractor requirements contained in this Contract must be propagated downward into any other lower tiered subcontracts. (45 C.F.R. 92.35).

9.4.5 Reimbursement rates and procedures for services provided under the subcontract.

9.4.6 Release to the Contractor of any information necessary to perform any of its obligations under this Contract.

9.4.7 Reasonable access to facilities and financial and medical records for duly authorized representatives of HCA or DHHS for audit purposes, and immediate access for Medicaid fraud investigators (42 C.F.R. § 438.6(g)).

9.4.8 The requirement to completely and accurately report encounter data to the Contractor. Contractor shall ensure that all subcontractors required to report encounter data have the capacity to submit all HCA required data to enable the

Contractor to meet the reporting requirements in the Encounter Data Transaction Guide published by HCA.

9.4.9 The requirement to comply with the Program Integrity requirements of this Contract and the Contractor's HCA approved program integrity policies and procedures.

9.4.10 No assignment of a subcontract shall take effect without HCA's written agreement.

9.4.11 The subcontractor shall comply with the applicable state and federal statutes, rules and regulations as set forth in this Contract, including but not limited to the applicable requirements of 42 U.S.C. § 1396a(a)(43), 1396d(r), 42 C.F.R. § 438.6(i).

9.4.12 Subcontracts shall set forth and require the subcontractor to comply with any term or condition of this Contract that is applicable to the services to be performed under the subcontract (42 C.F.R. § 438.6(1)).

9.4.13 The Contractor shall provide the following information regarding the grievance system to all subcontractors (42 C.F.R. § 438.414 and 42 C.F.R. § 438.10(g)(1)):

9.4.13.1 The toll-free numbers to file oral grievances and appeals.

9.4.13.2 The availability of assistance in filing a grievance or appeal.

9.4.13.3 The enrollee’s right to request continuation of benefits during an appeal or hearing and, if the Contractor’s action is upheld, that the enrollee may be responsible to pay for the continued benefits.

9.4.13.4 The enrollee’s right to file grievances and appeals and their requirements and timeframes for filing.

9.4.13.5 The enrollee’s right to a hearing, how to obtain a hearing and representation rules at a hearing.

9.4.14 The process for revoking delegation or imposing other sanctions if the subcontractor’s performance is inadequate.

9.4.15 A process for monitoring the subcontractor’s performance and a periodic schedule for formally evaluating performance, consistent with industry standards or State managed care laws and regulations.

9.4.16 The process whereby the subcontractor evaluates and ensures that services furnished to individuals with special health care needs are appropriate to the enrollee’s needs.

9.4.17 The Contractor shall evaluate any prospective subcontractor’s ability to perform the activities for which that subcontractor is contracting, including the

subcontractor's ability to perform delegated activities described in the subcontracting document.

9.5 Health Care Provider Subcontracts

The Contractor's subcontracts, including those for facilities and pharmacy benefit management, shall also contain the following provisions:

9.5.1 A quality improvement system tailored to the nature and type of services subcontracted, which affords quality control for the health care provided, including but not limited to the accessibility of medically necessary health care, and which provides for a free exchange of information with the Contractor to assist the Contractor in complying with the requirements of this Contract.

9.5.2 A statement that primary care and specialty care provider subcontractors shall cooperate with Quality Improvement (QI) activities.

9.5.3 A means to keep records necessary to adequately document services provided to enrollees for all delegated activities including Quality Improvement, Utilization Management, Member Rights and Responsibilities, and Credentialing and Recredentialing.

9.5.4 Delegated activities are documented and agreed upon between Contractor and subcontractor. The document must include:

9.5.4.1 Assigned responsibilities

9.5.4.2 Delegated activities

9.5.4.3 A mechanism for evaluation

9.5.4.4 Corrective action policy and procedure

9.5.5 Information about enrollees, including their medical records, shall be kept confidential in a manner consistent with state and federal laws and regulations.

9.5.6 The subcontractor accepts payment from the Contractor as payment in full; shall not request payment from HCA or any enrollee for contracted services performed under the subcontract, and shall comply with WAC 182-502-160 requirements applicable to providers.

9.5.7 The subcontractor agrees to hold harmless HCA and its employees, and all enrollees served under the terms of this Contract in the event of non-payment by the Contractor. The subcontractor further agrees to indemnify and hold harmless HCA and its employees against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against HCA or its employees through the intentional misconduct, negligence, or omission of the subcontractor, its agents, officers, employees or contractors (42 C.F.R. § 438.230(b)(2)).

9.5.8 If the subcontract includes physician services, provisions for compliance with the Performance Improvement Project (PIP) requirements stated in this Contract.

9.5.9 A ninety (90) day termination notice provision.

9.5.10 A specific termination provision for termination with short notice when a subcontractor is excluded from participation in the Medicaid program.

9.5.11 The subcontractor agrees to comply with the appointment wait time standards of this Contract. The subcontract must provide for regular monitoring of timely access and corrective action if the subcontractor fails to comply with the appointment wait time standards (42 C.F.R. § 438.206(c)(1)).

9.5.12 A provision for ongoing monitoring and periodic formal review that is consistent with industry standards and OIC regulations. Formal review must be completed no less than once every three years and must identify deficiencies or areas for improvement and provide for corrective action (42 C.F.R. § 438.230(b)).

9.5.13 The Contractor shall document and confirm in writing all single case agreements with providers. The agreement shall include:

9.5.13.1 The description of the services;

9.5.13.2 The authorization period for the services, including the begin date and the end date for approved services;

9.5.13.3 The rate of reimbursement for the service or reference to the Contractor's fee schedule or other plan documents that define payment; and

9.5.13.4 Any other specifics of the negotiated rate.

9.5.14 The Contractor must supply documentation to the subcontractor no later than five (5) business days following the signing of the agreement. Updates to the unique contract, must include all elements (begin date, end date, rate of care or reference to fee schedule and any other specifics regarding the services or payment methods).

9.5.15 The Contractor shall maintain a record of the single case agreements for a period of six (6) years.

9.6 Health Care Provider Subcontracts Delegating Administrative Functions

9.6.1 Subcontracts that delegate administrative functions under the terms of this Contract shall include the following additional provisions:

9.6.1.1 For those subcontractors at financial risk, that the subcontractor shall

maintain the Contractor's solvency requirements throughout the term of the Contract.

9.6.1.2 Clear descriptions of any administrative functions delegated by the Contractor in the subcontract. Administrative functions are any obligations of the Contractor under this Contract other than the direct provision of services to enrollees and include, but are not limited to, utilization/medical management, claims processing, enrollee grievances and appeals, and the provision of data or information necessary to fulfill any of the Contractor's obligations under this Contract.

9.6.1.3 How frequently and by what means the Contractor will monitor compliance with solvency requirements and subcontractor performance related to any administrative function delegated in the subcontract.

9.6.1.4 Provisions for revoking delegation or imposing sanctions if the subcontractor's performance is inadequate (42 C.F.R. § 438.230(b)(2)).

9.6.1.5 Whether referrals for enrollees will be restricted to providers affiliated with the group and, if so, a description of those restrictions.

9.6.1.6 Prior to delegation, an evaluation of the subcontractors ability to successfully perform and meet the requirements of this Contract for any delegated administrative function.

9.6.2 The Contractor shall submit a report of all current delegated entities, activities delegated and the number of enrollees assigned or serviced by the delegated entity to the HCA as part of the annual monitoring review, or as required by the HCA.

9.7 Health Homes

The Contractor shall subcontract with community entities sufficient in quantity and type to provide the intensive services defined in Section 14, Care Coordination, and Exhibit C, Health Homes of this Contract. The Contractor shall provide health home services as part of a qualified health home, or may enter into subcontractor agreements with Health Homes, qualified by the State to deliver health home services for enrollees meeting the criteria for Health Home services.

9.8 Home Health Providers

The Contractor may not subcontract with a home health agency unless the home health agency is in compliance with the surety bond requirements of federal law (Section 4708(d) of the Balanced Budget Act of 1997 and 42 C.F.R. § 441.16).

9.9 **Physician Incentive Plans**

Physician incentive plans, as defined herein, are subject to the conditions set forth in this Section in accord with federal regulations (42 C.F.R. § 438.6(h), 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210).

9.9.1 Prohibited Payments: The Contractor shall make no payment to a physician or physician group, directly or indirectly, under a physician incentive plan as an inducement to reduce or limit medically necessary services provided to an individual enrollee.

9.9.2 Disclosure Requirements: Risk sharing arrangements in subcontracts with physicians or physician groups are subject to review and approval by HCA. Prior to entering into, modifying or extending the risk sharing arrangement in a subcontract at any tier, the Contractor shall provide the following information about its physician incentive plan, and the physician incentive plans of its subcontractors to HCA:

9.9.2.1 A description of the incentive plan including whether the incentive plan includes referral services.

9.9.2.2 If the incentive plan includes referral services, the information provided to HCA shall include:

9.9.2.2.1 The type of incentive plan (e.g. withhold, bonus, capitation).

9.9.2.2.2 For incentive plans involving withholds or bonuses, the percent that is withheld or paid as a bonus.

9.9.2.2.3 Proof that stop-loss protection meets the requirements identified within the provisions of this Section, including the amount and type of stop-loss protection.

9.9.2.2.4 The panel size and, if commercial members and enrollees are pooled, a description of the groups pooled and the risk terms of each group. Medicaid, Medicare, and commercial members in a physician's or physician group's panel may be pooled provided the terms of risk for the pooled enrollees and commercial members are comparable, and the incentive payments are not calculated separately for pooled enrollees. Commercial members include military members.

9.9.3 If the Contractor, or any subcontractor, places a physician or physician group at substantial financial risk, the Contractor shall assure that all physicians and physician groups have either aggregate or per member stop-loss protection for services not directly provided by the physician or physician group.

9.9.3.1 If aggregate stop-loss protection is provided, it must cover ninety percent (90%) of the costs of referral services that exceed twenty-five percent (25%) of maximum potential payments under the subcontract.

9.9.3.2 If stop-loss protection is based on a per-member limit, it must cover ninety percent (90%) of the cost of referral services that exceed the limit as indicated below based on panel size, and whether stop-loss is provided separately for professional and institutional services or is combined for the two.

9.9.3.2.1 1,000 members or fewer, the threshold is $3,000 for professional services and $10,000 for institutional services, or $6,000 for combined services.

9.9.3.2.2 1,001 - 5,000 members, the threshold is $10,000 for professional services and $40,000 for institutional services, or $30,000 for combined services.

9.9.3.2.3 5,001 - 8,000 members, the threshold is $15,000 for professional services and $60,000 for institutional services, or $40,000 for combined services.

9.9.3.2.4 8,001 - 10,000 members, the threshold is $20,000 for professional services and $100,000 for institutional services, or $75,000 for combined services.

9.9.3.2.5 10,001 - 25,000, the threshold is $25,000 for professional services and $200,000 for institutional services, or $150,000 for combined services.

9.9.3.2.6 25,001 members or more, there is no risk threshold.

9.9.3.3 For a physician or physician group at substantial financial risk, the Contractor shall conduct surveys of enrollee satisfaction with the physician or physician group on an annual basis. The survey shall:

9.9.3.3.1 Be approved by HCA.

9.9.3.3.2 Be conducted according to commonly accepted principles of survey design and statistical analysis.

9.9.3.3.3 Address enrollee satisfaction with the physician or physician group, quality of services provided; and degree of access to services.

9.9.3.3.4 Report survey results to the HCA and, upon request, to enrollees.

9.10 **Provider Education**

The Contractor will maintain records of the number and type of providers and support staff participating in provider education, including evidence of assessment of participant satisfaction from the training process.

9.10.1 The Contractor shall maintain a system for keeping participating providers informed about:

9.10.1.1 Covered services for enrollees served under this Contract.

9.10.1.2 Coordination of care requirements.

9.10.1.3 HCA and the Contractor's policies and procedures as related to this Contract.

9.10.1.4 Health Homes.

9.10.1.5 HCA First Steps Program - Maternity Support Services (MSS). The Contractor shall notify providers about HCA's First Steps program, MSS, using the HCA MSS informational letter template which includes the HCA First Steps program website and Provider Directory.

9.10.1.6 Interpretation of data from the Quality Improvement program.

9.10.1.7 Practice guidelines as described in the provisions of this Contract.

9.10.1.8 Mental health services through the Contractor. The Contractor shall provide an annual list showing all of its contracted mental health professionals to all primary care providers, including pediatric primary care providers. The Contractor shall provide the list to its primary care providers no later than January 31, 2015.

9.10.1.9 Mental health services through DSHS Regional Support Networks including a list of Regional Support Networks and contact information in counties served by the Contractor.

9.10.1.10 DSHS substance use disorder services, including a list of Substance Use Disorder Clinics and contact information located in the counties served by the Contractor.

9.10.1.11 Contractor care management staff for assistance in care transitions and care management activity.

9.10.1.12 Program Integrity requirements.

9.10.1.13 DSHS long-term care services including availability of home and community based care.

9.10.1.14 Educational opportunities for primary care providers, such as those

produced by the Washington State Department of Health Collaborative, the Washington State Medical Association or the Washington State Hospital Association, etc.

9.11 Claims Payment Standards

9.11.1 The Contractor shall meet the timeliness of payment standards specified for Medicaid fee-for-service in Section 1902(a)(37)(A) of the Social Security Act, 42 C.F.R. § 447.46 and specified for health carriers in WAC 284-43-321. To be compliant with both payment standards the Contractor shall pay or deny, and shall require subcontractors to pay or deny, ninety-five percent (95%) of clean claims within thirty (30) calendar days of receipt, ninety-five percent (95%) of all claims within sixty (60) of receipt and ninety-nine percent (99%) of clean claims within ninety (90) calendar days of receipt. The Contractor and its providers may agree to a different payment requirement in writing on an individual claim.

9.11.1.1 A claim is a bill for services, a line item of service or all services for one enrollee within a bill.

9.11.1.2 A clean claim is a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

9.11.1.3 The date of receipt is the date the Contractor receives the claim from the provider.

9.11.1.4 The date of payment is the date of the check or other form of payment.

9.11.2 The Contractor shall conduct and submit to HCA an annual claims denial analysis report. The report shall be due April 1, 2016, reflecting the 2015 calendar year. The report shall include the following data:

9.11.2.1 Total number of claims denied by claim line.

9.11.2.2 Total number of claims approved by claim line.

9.11.2.3 Top five reasons for claims denied.

9.11.2.4 The proportion of aggregated top five reasons for claims denied by claim line divided by total denied claim lines.

9.11.2.5 The proportion of claim lines denied in error and subsequently adjusted to total claims denied.

9.11.2.6 The total number of denied claims divided by the total number of claims.

9.11.2.7 The five subcontractors with the highest aggregated denied claim

lines expressed as a ratio.

9.11.3 The report shall include a narrative, including the action steps planned to address:

9.11.3.1 The top five reasons for denial, including steps taken with the top five subcontractors to educate the subcontractors on actions to address root causes of denied claims.

9.11.3.2 Claims denied in error by the Contractor.

9.12 **Federally Qualified Health Centers / Rural Health Clinics Report**

The Contractor shall provide HCA with information related to subcontracted federally qualified health centers (FQHC) and rural health clinics (RHC), as required by HCA Federally Qualified Health Center and Rural Health Center Billing Guides, published by HCA and incorporated by reference into this Contract.

9.13 **Provider Credentialing**

The Contractor's policies and procedures shall follow the state's requirements related to the credentialing and recredentialing of health care professionals who have signed contracts or participation agreements with the Contractor (Chapter 246-12 WAC). The Contractor shall ensure and demonstrate compliance with the requirements described in this Contract.

9.13.1 The Contractor's policies and procedures shall ensure compliance with the following requirements described in this section.

9.13.1.1 The Contractor's medical director or other designated physician shall have direct responsibility for and participation in the credentialing program.

9.13.1.2 The Contractor shall have a designated Credentialing Committee to oversee the credentialing process.

9.13.2 The Contractor's credentialing and recredentialing program shall include:

9.13.2.1 Identification of the type of providers credentialed and recredentialed.

9.13.2.2 Specification of the verification sources used to make credentialing and recredentialing decisions, including any evidence of provider sanctions.

9.13.2.3 A process for provisional credentialing that affirms that:

9.13.2.3.1 The practitioner may not be held in a provisional status for more than sixty (60) calendar days; and

9.13.2.3.2 The provisional status will only be granted one time and only for providers applying for credentialing the first time.

9.13.2.3.3 Provisional credentialing shall include an assessment of:

9.13.2.3.3.1 Primary source verification of a current, valid license to practice;

9.13.2.3.3.2 Primary source verification of the past five years of malpractice claims or settlements from the malpractice carrier or the results of the National Practitioner Databank query; and

9.13.2.3.3.3 A current signed application with attestation.

9.13.2.4 Prohibition against employment or contracting with providers excluded from participation in Federal health care programs under federal law and as described in the Excluded Individuals and Entities provisions of this Contract.

9.13.2.5 A detailed description of the Contractor's process for delegation of credentialing and recredentialing.

9.13.2.6 Verification of provider compliance with all Program Integrity requirements in this Contract.

9.13.3 The Contractor's process for communicating findings to the provider that differ from the provider's submitted materials shall include communication of the provider's rights to:

9.13.3.1 Review materials.

9.13.3.2 Correct incorrect or erroneous information.

9.13.3.3 Be informed of their credentialing status.

9.13.4 The Contractor's process for notifying providers within sixty (60) calendar days of the credentialing committee's decision.

9.13.5 An appeal process for providers for quality reasons and reporting of quality issues to the appropriate authority and in accord with the Program Integrity requirements of this Contract.

9.13.6 The Contractor's process to ensure confidentiality.

9.13.7 The Contractor's process to ensure listings in provider directories for enrollees are consistent with credentialing file content, including education, training, certification and specialty designation.

9.13.8 The Contractor's process for recredentialing providers at minimum every thirty-

six (36) months through information verified from primary sources, unless otherwise indicated.

9.13.9 The Contractor's process to ensure that offices of all health care professionals meet office site standards established by the Contractor.

9.13.10 The Contractor's system for monitoring sanctions, limitations on licensure, complaints and quality issues or information from identified adverse events and provide evidence of action, as appropriate based on defined methods or criteria.(42 C.F.R. § 455.101).

9.13.11 The Contractor's process and criteria for assessing and reassessing organizational providers.

9.13.12 The criteria used by the Contractor to credential and recredential practitioners shall include (42 C.F.R. § 438.230(b)(1)):

9.13.12.1 Evidence of a current valid license to practice;

9.13.12.2 A valid DEA or CDS certificate if applicable;

9.13.12.3 Evidence of appropriate education and training;

9.13.12.4 Board certification if applicable;

9.13.12.5 Evaluation of work history;

9.13.12.6 A review of any liability claims resulting in settlements or judgments paid on or on behalf of the provider; and

9.13.12.7 A signed, dated attestation statement from the provider that addresses:

9.13.12.7.1 The lack of present illegal drug use;

9.13.12.7.2 A history of loss of license and criminal or felony convictions;

9.13.12.7.3 A history of loss or limitation of privileges or disciplinary activity;

9.13.12.7.4 Current malpractice coverage;

9.13.12.7.5 Any reason(s) for inability to perform the essential functions of the position with or without accommodation; and

9.13.12.7.6 Accuracy and completeness of the application.

9.13.12.8 Verification of the: National Provider Identifier, the provider's

enrollment as a Washington Medicaid provider, and the Social Security Administration's death master file.

9.13.13 The Contractor shall ensure that all subcontracted providers defined as "high categorical risk" in 42 C.F.R. § 424.518, are enrolled through the Medicare system, which requires a criminal background check as part of the enrollment process. The Contractor shall ensure that each provider defined as "high categorical risk" provide an enrollment verification letter from Medicare issued after March 23, 2011 as part of the credentialing process. The contractor shall ensure that contracted providers defined as "high categorical risk" revalidate their Medicare enrollment every three (3) years in compliance with 42 C.F.R. § 424.515.

9.13.14 The Contractor shall terminate any provider where HCA or Medicare has taken any action to revoke the provider's privileges for cause, and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. For cause may include, but is not limited to, fraud; integrity; or quality (42 C.F.R. § 455.101).

9.13.15 The Contractor shall notify HCA in accord with the Notices section of this contract, within three (3) business days of receipt of information relating to disciplinary action against the accreditation, certification, license and/or registration of the Contractor, an employee, subcontractor or subcontractor employee.

9.13.16 The Contractor shall require providers defined as "high categorical risk" for potential fraud as defined in 42 C.F.R. § 424.518 to be enrolled and screened by Medicare.

9.13.17 The Contractor's policies and procedures shall be consistent with 42 C.F.R. § 438.12, and the process shall ensure the Contractor does not discriminate against particular health care professionals that serve high-risk populations or specialize in conditions that require costly treatment, and any other methods for assuring nondiscrimination.

10 ENROLLEE RIGHTS AND PROTECTIONS

10.1 General Requirements

10.1.1 The Contractor shall comply with any applicable Federal and State laws that pertain to enrollee rights and ensure that its staff and affiliated providers protect and promote those rights when furnishing services to enrollees (42 C.F.R. § 438.100(a)(2)).

10.1.2 The Contractor shall have in place written policies that guarantee each enrollee the following rights (42 C.F.R. § 438.100(b)(2)):

10.1.2.1 To be treated with respect and with consideration for their dignity and privacy (42 C.F.R. § 438.100(b)(2)(ii)).

10.1.2.2 To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's ability to understand (42 C.F.R. § 438.100(b)(2)(iii)).

10.1.2.3 To participate in decisions regarding their health care, including the right to refuse treatment (42 C.F.R. § 438.100(b)(2)(IV)).

10.1.2.4 To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation (42 C.F.R. § 438.100(b)(2)(IV)).

10.1.2.5 To request and receive a copy of their medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164 (42 C.F.R. § 438.100(b)(2)(iv)).

10.1.2.6 Each enrollee must be free to exercise their rights, and exercise of those rights must not adversely affect the way the Contractor or its subcontractors treat the enrollee (42 C.F.R. § 438.100(c)).

10.2 **Cultural Considerations**

10.2.1 The Contractor shall participate in and cooperate with HCA efforts to promote the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. The Contractor will provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. (42 C.F.R. § 438.206(c)(2)).

10.2.2 At a minimum, the Contractor shall:

10.2.2.1 Offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each enrollee with limited English proficiency at all points of contact, in a timely manner during all hours of operation. (CLAS Standard 4);

10.2.2.2 Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services. (CLAS Standard 5);

10.2.2.3 Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing. (CLAS Standard 6);

10.2.2.4 Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as

interpreters should be avoided. (CLAS Standard 7);

10.2.2.5 Provide easy–to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area. (CLAS 8);

10.2.2.6 Establish culturally and linguistically appropriate goals. (CLAS Standard 9);

10.2.2.7 Conduct ongoing assessments of the organization's CLAS–related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities. (CLAS Standard 10);

10.2.2.8 Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery. (CLAS 11); and

10.2.2.9 Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflict or complaints. (CLAS 14).

10.2.3 No later January 31. 2016, for the period calendar year 2015, the Contractor shall provide HCA with an annual report evidencing its compliance with each CLAS standard.

10.3 **Advance Directives and Physician Orders for Life Sustaining Treatment (POLST)**

10.3.1 The Contractor shall meet the requirements of WAC 182-501-0125, 42 C.F.R. § 438.6, 438.10, 422.128, 489.100 and 489 Subpart I as described in this section.

10.3.2 The Contractor's advance directive policies and procedures shall be disseminated to all affected providers, enrollees, HCA, and, upon request, potential enrollees (42 C.F.R. § 438.6(i)(3)).

10.3.2.1 The Contractor shall develop policies and procedures to address Physician Orders for Life Sustaining Treatment (POLST) and ensure that they are distributed in the same manner as those governing advance directives.

10.3.3 The Contractor's written policies respecting the implementation of advance directive POLST rights shall include a clear and precise statement of limitation if the Contractor cannot implement an advance directive as a matter of conscience (42 C.F.R. § 422.128). At a minimum, this statement must do the following:

10.3.3.1 Clarify any differences between Contractor conscientious objections and those that may be raised by individual physicians.

10.3.3.2 Identify the state legal authority permitting such objection.

10.3.3.3 Describe the range of medical conditions or procedures affected by the conscience objection.

10.3.4 If an enrollee is incapacitated at the time of initial enrollment and is unable to receive information (due to the incapacitating condition or a mental disorder) or articulate whether or not he or she has executed an advance directive or received a POLST, the Contractor may give advance directive information to the enrollee's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated enrollee or to a surrogate or other concerned persons in accord with State law. The Contractor is not relieved of its obligation to provide this information to the enrollee once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to ensure that the information is given to the individual directly at the appropriate time.

10.3.5 The Contractor must require and ensure, that the enrollee's medical record documents, in a prominent part, whether or not the individual has executed an advance directive or received a POLST.

10.3.6 The Contractor shall not condition the provision of care or otherwise discriminate against an enrollee based on whether or not the enrollee has executed an advance directive or received a POLST.

10.3.7 The Contractor shall ensure compliance with requirements of State and Federal law (whether statutory or recognized by the courts of the State) regarding advance directives or POLSTs.

10.3.8 The Contractor shall provide for education of staff concerning its policies and procedures on advance directives or POLSTs.

10.3.9 The Contractor shall provide for community education regarding advance directives that may include material required herein, either directly or in concert with other providers or entities. Separate community education materials may be developed and used, at the discretion of the Contractor. The same written materials are not required for all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual's control over medical treatment, and describe applicable State and Federal law concerning advance directives. The Contractor shall document its community education efforts (42 C.F.R. § 438.6(i)(3)).

10.3.10 The Contractor is not required to provide care that conflicts with an advance directive; and is not required to implement an advance directive if, as a matter of conscience, the Contractor cannot implement an advance directive and State law allows the Contractor or any subcontractor providing services under this Contract to conscientiously object.

10.3.11 The Contractor shall inform enrollees that they may file a grievance with the Contractor if the enrollee is dissatisfied with the Contractor's advance directive policy and procedure or the Contractor's administration of those policies and

procedures. The Contractor shall also inform enrollees that they may file a grievance with the Washington State Department of Health if they believe the Contractor is non-compliant with advance directive and POLST requirements.

10.4 Enrollee Choice of PCP

10.4.1 The Contractor must implement procedures to ensure each enrollee has a source of primary care appropriate to their needs (42 C.F.R. § 438.207(c)).

10.4.2 The Contractor shall allow, to the extent possible and appropriate, each new enrollee to choose a participating PCP (42 C.F.R. § 438.6(m)).

10.4.3 In the case of newborns, the parent shall choose the newborn's PCP.

10.4.4 In the case of Alaska Native or American Indian enrollees, the enrollee may choose a tribal clinic as his or her PCP, whether or not the tribal clinic is a network provider.

10.4.5 If the enrollee does not make a choice at the time of enrollment, the Contractor shall assign the enrollee to a PCP or clinic, within reasonable proximity to the enrollee's home, no later than fifteen (15) business days after coverage begins.

10.4.6 The Contractor shall allow an enrollee to change PCP or clinic at any time with the change becoming effective no later than the beginning of the month following the enrollee's request for the change (WAC 182-538-060 and WAC 284-43-251(1)).

10.4.7 The Contractor may limit an enrollee's ability to change PCP's in accord with the Patient Review and Coordination provisions of this Contract.

10.5 Prohibition on Enrollee Charges for Covered Services

10.5.1 Under no circumstances shall the Contractor, or any providers used to deliver services under the terms of this Contract, including non-participating providers, charge enrollees for covered services as described in the (SSA 1932(b)(6), SSA 1128B(d)(1)), 42 C.F.R. § 438.106(c), 438.6(1), 438.230, 438.204(a) and WAC 182-502-0160).

10.5.2 Prior to authorizing services with non-participating providers, the Contractor shall assure that non-participating providers fully understand and accept the prohibition against balance billing enrollees.

10.5.3 The Contractor shall require providers to report when an enrollee is charged for services. The Contractor shall maintain a central record of the charged amount, enrollee's agreement to pay, if any, and actions taken regarding the billing by the Contractor. The Contractor shall be prepared at any time to report to HCA any and all instances where an enrollee is charged for services, whether or not those charges are appropriate.

10.5.4 If an enrollee has paid inappropriate charges, the Contractor will make every effort to have the provider repay the enrollee the inappropriate amount. If the Contractor's efforts to have the provider repay the enrollee fail, the Contractor will repay the enrollee the inappropriately charged amount.

10.5.5 The Contractor shall have a separate and specific policy and procedure that fully articulates how the Contractor will protect enrollees from being billed for contracted services.

10.5.6 The Contractor shall coordinate benefits with other insurers in a manner that does not result in any payment by or charges to the enrollee for covered services including other insurer's copayments and coinsurance.

10.6 Provider/Enrollee Communication

The Contractor may not prohibit, or otherwise restrict, a health care professional acting within their lawful scope of practice, from advising or advocating on behalf of an enrollee who is their patient, for the following (42 C.F.R. § 438.102(a)(1)(i)):

10.6.1 The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered (42 C.F.R. § 438.102(a)(1)(i)).

10.6.2 Any information the enrollee needs in order to decide among all relevant treatment options (42 C.F.R. § 438.102(a)(1)(ii)).

10.6.3 The risks, benefits, and consequences of treatment or non-treatment (42 C.F.R. § 438.102(a)(1)(iii)).

10.6.4 The enrollee's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions (42 C.F.R. § 438.102(a)(1)(iv)).

10.7 Enrollee Self-Determination

The Contractor shall ensure that all providers: obtain informed consent prior to treatment from enrollees, or persons authorized to consent on behalf of an enrollee as described in RCW 7.70.065; comply with the provisions of the Natural Death Act (Chapter 70.122 RCW) and state and federal Medicaid rules concerning advance directives (WAC 182-501-0125 and 42 C.F.R. § 438.6(m)); and, when appropriate, inform enrollees of their right to make anatomical gifts (Chapter 68.64 RCW).

10.8 Women's Health Care Services

The Contractor must provide female enrollees with direct access to a women's health practitioners within the Contractor's network for covered care necessary to provide women's routine and preventive health care services, including prescriptions for pharmaceutical or medical supplies ordered by a directly accessed women's health care practitioner, and which are in the practitioner's scope of practice in accord with the provisions of WAC 284-43-250 and 42 C.F.R. § 438.206(b)(2).

10.9 **Maternity Newborn Length of Stay**

The Contractor shall ensure that hospital delivery maternity care is provided in accord with RCW 48.43.115.

10.10 **Enrollment Not Discriminatory**

10.10.1 The Contractor will not discriminate against enrollees due to an adverse change in the enrollee's health status, the cost of meeting the enrollee's health care needs, because of the enrollee's utilization of medical services, diminished mental capacity, uncooperative or disruptive behavior resulting from their special needs or treatable mental health condition (WAC 182-538-130 and 42 C.F.R. § 438.56(b)(2)).

10.10.2 No eligible person shall be refused enrollment or re-enrollment, be terminated from enrollment, or be discriminated against in any way because of health status, including the existence of a pre-existing physical or mental condition, functional impairment or chemical dependency, pregnancy and/or hospitalization, or the expectation of the need for frequent or high cost care (42 C.F.R. § 438.6(d)(1 and 3)).

10.10.3 The Contractor will not discriminate against enrollees or those eligible to enroll on the basis of race, color, or national origin, gender, age, veteran or military status, sexual orientation, or the presence of any sensory, mental or physical disability, or the use of a trained dog guide or service animal by a person with a disability, and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin (42 C.F.R. § 438.6(d)(4)) and U.S.C. 18116.

11 UTILIZATION MANAGEMENT PROGRAM AND AUTHORIZATION OF SERVICES

11.1 **Utilization Management Requirements)**

The Contractor shall follow the Utilization Management requirements described in this section.

11.1.1 The Contractor’s policies and procedures related to Utilization Management (UM) shall comply with, and require the compliance of subcontractors with delegated authority for Utilization Management, the requirements described in this section.

11.1.2 The Contractor shall have and maintain a Utilization Management Program (UMP) description for the physical and behavioral services it furnishes its enrollees (WAC 284-43-410(2)).

11.1.3 The Contractor shall define its UMP structure and assign responsibility for UMP activities to appropriate individuals.

11.1.4 The Contractor shall provide HCA with meeting minutes and a written description of the UMP that includes identification of designated physician responsible for

program implementation, oversight and evaluation and behavioral health practitioners and evidence of the physician and behavioral health practitioner's involvement in program development and implementation.

11.1.5 The UMP program description shall include:

11.1.5.1 A written description of all UM-related committee(s)

11.1.5.2 Descriptions of committee responsibilities

11.1.5.3 Contractor staff and practicing provider committee participant title(s)

11.1.5.4 Meeting frequency

11.1.5.5 Maintenance of signed meeting minutes reflecting decisions made by each committee, as appropriate

11.1.5.6 Annually evaluate and update the UMP.

11.1.6 UMP behavioral health and non-behavioral health policies and procedures at minimum, shall address the following requirements:

11.1.6.1 Documentation of use and periodic review of written clinical decision-making criteria based on clinical evidence, including policies and procedures for appropriate application of the criteria (WAC 284-43-410(2)).

11.1.6.2 Written policies for applying UMP decision-making criteria based on individual enrollee needs, such as age, comorbidities, complications and psychosocial and home environment characteristics, where applicable; and the availability of services in the local delivery system.

11.1.6.3 Mechanisms for providers and enrollees on how they can obtain the UM decision-making criteria upon request, including UM action or denial determination letter template language reflecting same (WAC 284-43-410(2)).

11.1.6.4 Mechanisms to facilitate communication between UMP staff and providers and enrollees.

11.1.6.5 Mechanisms for at least annual assessment of inter-rater reliability of all clinical professionals and as appropriate, non-clinical staff responsible for UM decisions.

11.1.6.6 Written job descriptions with qualification for providers who review denials of care based on medical necessity that requires education, training or professional experience in medical or clinical practice and current, non-restricted license.

11.1.6.7 Mechanisms to verify that claimed services were actually provided.

11.1.6.8 Mechanisms to detect both underutilization and over-utilization of services, including pharmacy underutilization and over-utilization.

11.1.6.9 The production of an annual report of the findings on quality and utilization measures and completed or planned interventions to address under or over-utilization patterns of care (42 C.F.R. § 438.240(b)(3)).

11.1.6.10 Identification of the type of personnel responsible for each level of UM decision-making.

11.1.6.11 A physician, doctoral level psychologist, certified addiction medicine specialist or pharmacist, as appropriate, reviews any behavioral health denial of care based on medical necessity.

11.1.6.12 The use of board certified consultants to assist in making medical necessity determinations.

11.1.6.13 Appeals of adverse determinations evaluated by health care providers who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered person's condition or disease (WAC 284-43-620(4)).

11.1.6.14 Documentation of timelines for appeals in accord with the Appeal Process provisions of the Grievance System Section of this Contract.

11.1.7 The Contractor shall follow the coverage decisions of the Health Technology Assessment (HTA) program (Chapter 182-55 WAC) specifically endorsed by HCA for the Apple Health population and, upon HCA's request, provide documentation demonstrating compliance (See http://www.hca.wa.gov/hta/Pages/index.aspx).

11.1.8 The Contractor shall not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee (42 C.F.R. § 438.210(e)).

11.1.9 The Contractor shall not penalize or threaten a provider or facility with a reduction in future payment or termination of participating provider or participating facility status because the provider or facility disputes the Contractor's determination with respect to coverage or payment for health care service.

11.2 **Medical Necessity Determination**

The Contractor shall collect all information necessary to make medical necessity determinations. (42 C.F.R § 456.111 and 456.211). The Contractor shall determine which

services are medically necessary, according to the definition of Medically Necessary Services in this Contract. The Contractor's determination of medical necessity in specific instances shall be final except as specifically provided in this Contract regarding appeals, hearings and independent review.

11.3 Authorization of Services

11.3.1 The Contractor shall follow the authorization of services requirements described in this section. The Contractor shall not have or implement authorization policies that inhibit enrollees from obtaining medically necessary contracted services and supplies.

11.3.2 Authorizations for contracted services and supplies that are needed on an ongoing basis shall not be required any more frequently than every six (6) months. Services and supplies needed on an ongoing basis include, but are not limited to, insulin pens, incontinence supplies, ongoing medications or medications for chronic conditions.

11.3.3 The Contractor's policies and procedures related to authorization and postservice authorization of services shall include compliance with 42 C.F.R. § 438.210, WAC 284-43-410, Chapters 182-538 and 182-550 WAC, WAC 182-501-0160 and 182-501-0169, and require compliance of subcontractors with delegated authority for authorization of services with the requirements described in this section, and shall include a definition of "service authorization" that includes an enrollee's request for services.

11.3.4 The Contractor shall provide education and ongoing guidance to providers to assist in utilizing the Contractor's authorization processes.

11.3.5 The Contractor shall evaluate its authorization requirements:

11.3.5.1 To identify the procedures or services that result in a high approval rate and eliminate prior authorization requirements on these procedures or services for which the return on investment does not warrant the administrative burden and costs..

11.3.5.2 To identify its contracted providers who have a high approval rate and exempt them from its prior approval requirements.

11.3.5.3 The Contractor shall document actions taken to streamline its authorization requirements and report these changes to HCA by September 1, 2015.

11.3.6 The Contractor shall have in effect mechanisms to ensure consistent application of UMP review criteria for authorization decisions (42 C.F.R. § 438.210(b)(1)(i)).

11.3.7 The Contractor shall consult with the requesting provider when appropriate (42 C.F.R. § 438.210(b)(2)(ii)).

11.3.7.1 The Contractor shall require that any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease (42 C.F.R. § 438.210(b)(3)).

11.3.7.2 The Contractor shall notify the requesting provider and give the enrollee written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The notice shall meet the following requirements (42 C.F.R. § 438.210(c) and 438.404):

11.3.7.2.1 The notice to the enrollee shall meet the requirements of the, Information Requirements for Enrollees and Potential Enrollees of this Contract to ensure ease of understanding.

11.3.7.2.2 The notice shall be mailed within two (2) business days of the Contractor's decision. For expedited authorization decisions, the Contractor shall also provide oral notice within the same timeframe.

11.3.7.2.3 The notice to the enrollee and provider shall explain the following (42 C.F.R. § 438.404(b)(1-3)(5-7)):

11.3.7.2.3.1 The action the Contractor has taken or intends to take.

11.3.7.2.3.2 The reasons for the action, in easily understood language and citation to any Contractor guidelines, protocols, or other criteria on which the decision was based in whole or in part, and either attached copies of each rule, guideline, protocol or other criterion cited, or the website citation for each.

11.3.7.2.3.3 The enrollee and providers right to request and receive free of charge a copy of the rule, guideline, protocol or other criterion that was the basis for the decision.

11.3.7.2.3.4 A statement whether or not an enrollee has any liability for payment.

11.3.7.2.3.5 A toll free telephone number to call if the enrollee is billed for services.

11.3.7.2.3.6 The enrollee's right to file an appeal and any deadlines applicable to the process.

11.3.7.2.3.7 The availability of Washington's designated ombudsman's office as referenced in the Affordable Care Act (Public Law 111-148).

11.3.7.2.3.8 If services are denied or authorized in a more limited scope than requested as non-covered, inform enrollees how to access the Exception to Rule (ETR) or Limitation Extension (LE) process including, but not limited to, the facts that an enrollee may appeal an action affecting his or her services and simultaneously request an ETR or LE to obtain the services that are the subject of the appeal, and that requesting an ETR or LE does not toll any deadlines applicable to the appeal process.

11.3.7.2.3.9 The procedures for exercising the enrollee's rights.

11.3.7.2.3.10 The circumstances under which expedited resolution is available and how to request it.

11.3.7.2.3.11 The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay for these services.

11.3.7.2.3.12 The enrollee's right to receive the Contractor's assistance with filing the appeal.

11.3.7.2.3.13 The enrollee's right to equal access to services for enrollees and potential enrollees with communications barriers and disabilities

11.3.7.2.4 In denying services, the Contractor will only deny a service as non-covered if HCA has determined that the service is non-covered under the fee-for-service program. For services that are excluded from this

Contract, but are covered by HCA, the Contractor's denial will include directions to the enrollee about how to obtain the services through HCA and will direct the enrollee to those services and coordinate receipt of those services.

11.3.8 The Contractor shall provide for the following timeframes for authorization decisions and notices:

11.3.8.1 For denial of payment that may result in payment liability for the enrollee, at the time of any action affecting the claim.

11.3.8.2 For termination, suspension, or reduction of previously authorized services, ten (10) calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. § 431.213 and 431.214 are met.

11.3.8.3 For standard authorizations for health care services determinations are to be made within five (5) calendar days of the receipt of necessary information, but are allowed up to fourteen (14) calendar days, if additional information is required and requested by the Contractor within five (5) calendar days of the original receipt of the request for services (42 C.F.R. § 438.210(d)(1) and WAC 284-43-410).

11.3.8.3.1 Beyond the fourteen (14) calendar day period, a possible extension of up to fourteen (14) additional calendar days (not to exceed twenty-eight (28) calendar days total) is allowed under the following circumstances (42 C.F.R. § 438.210(d)(1)(i-ii)):

11.3.8.3.1.1 The enrollee or the provider requests extensions;

11.3.8.3.1.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest; or

11.3.8.3.1.3 If the Contractor extends that timeframe, it shall (42 C.F.R. § 438.210(d)(4) give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the enrollee's health condition requires and no

later than the date the extension expires; or

11.3.8.3.1.4 For service authorization decisions not reached within the timeframes specified in 42 C.F.R. § 438.210(d) (which constitutes a denial and is thus an adverse action), on the date that the timeframes expire.

11.3.8.4 All authorization determinations for prescriptions or over-the-counter drugs must be made no later than the following business day after receipt of the request for service unless additional information is required. Any additional information needed must be requested within one business day of the initial request for authorization and determinations must be made no later than one business day after receipt of the additional information.

11.3.8.5 For cases in which a provider indicates, or the Contractor determines, that following the timeframe for standard authorization decisions could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires. If the lack of treatment may result in an emergency visit or emergency admission the decision must be made no later than twenty-four (24) hours after receipt of the request for service. For all other urgent requests for service the decision must be made within forty-eight (48) hours. The Contractor may extend the time period by up to fourteen (14) calendar days under the following circumstances (42 C.F.R. § 438.210(d)(2)):

11.3.8.5.1 The enrollee requests the extension; or

11.3.8.5.2 The Contractor justifies and documents a need for additional information and how the extension is in the enrollee's interest.

11.3.8.6 For concurrent review authorizations, the Contractor must make its determination within one (1) business day of receipt of the request for authorization.

11.3.8.6.1 Requests to extend concurrent care review authorization determinations may be extended to within three (3) business days of the request of the authorization, if the Contractor has made at least one attempt to obtain needed clinical information within the initial one (1) business day after the request for authorization of additional days or services.

11.3.8.6.2 Notification of the concurrent review determination shall be made within one (1) business day of the Contractor's decision.

11.3.8.6.3 Expedited appeal timeframes apply to concurrent review requests.

11.3.8.7 For postservice authorizations, including pharmacy postservice decisions, the Contractor must make its determination within thirty (30) calendar days of receipt of the authorization request.

11.3.8.7.1 The Contractor shall notify the enrollee and the requesting provider within two (2) business days of the Contractor's determination.

11.3.8.7.2 Standard appeal timeframes apply to postservice denials.

11.3.8.7.3 When postservice authorizations are approved they become effective the date the service was first administered.

11.3.8.8 For all adverse determinations, the Contractor must notify the ordering provider, facility, and the enrollee. The Contractor must inform the parties, other than the enrollee, in advance whether it will provide notification by phone, mail, fax, or other means. The Contractor must notify the enrollee in writing of the decision. For an adverse authorization decision involving an expedited authorization request the Contractor may initially provide notice orally. For all adverse authorization decisions, the Contractor shall provide written notification within seventy-two (72) hours of the decision. (PBOR, WAC 284-43-410).

11.3.8.8.1 The Contractor shall give notice at least five (5) calendar days before the date of action when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services when enrollee fraud has been verified.

11.3.8.9 The Contractor shall provide notification in accord with the timeframes described in Subsection 11.3.5.2 in the following circumstances:

11.3.8.9.1 The enrollee dies;

11.3.8.9.2 The Contractor has a signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services (where the enrollee understands that termination, reduction or

suspension of services is the result of supplying this information);

11.3.8.9.3 The enrollee is admitted to an institution where he or she is ineligible for services;

11.3.8.9.4 The enrollee's address is unknown and mail directed to him or her has no forwarding address;

11.3.8.9.5 The enrollee has moved out of the Contractor's service area;

11.3.8.9.6 The enrollee's PCP prescribes the change in the level of medical care;

11.3.8.9.7 An adverse determination made with regard to the preadmission screening for nursing facility was made by Home and Community Services;

11.3.8.9.8 The safety or health of individuals in the nursing facility would be endangered, the enrollee's health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the enrollee's urgent medical needs, or an enrollee has not resided in the nursing facility for thirty (30) calendar days (applies only to adverse actions for nursing facility transfers).

11.3.8.10 Untimely Service Authorization Decisions: When the Contractor does not reach service authorization decisions within the timeframes for either standard or expedited service authorizations it is considered a denial and thus, an adverse action.

11.4 Experimental and Investigational Services for Managed Care Enrollees

11.4.1 In determining whether a service that the Contractor considers experimental or investigational is medically necessary for an individual enrollee, the Contractor must have and follow policies and procedures that mirror the process for HCA's medical necessity determinations for its fee-for-service program described in WAC 182-501-0165. Medical necessity decisions are to be made by a qualified healthcare professional and must be made for an individual enrollee based on that enrollee's health condition. The policies and procedures shall identify the persons responsible for such decisions. The policies and procedures and any criteria for making decisions shall be made available to HCA upon request.

11.4.2 Criteria to determine whether an experimental or investigational service is medically necessary shall be no more stringent for Medicaid enrollees than that applied to any other members.

11.4.3 An adverse determination made by the Contractor shall be subject to appeal

through the Contractor's appeal process, hearing process and independent review in accordance with the Grievance System Section of this Contract.

11.5 Compliance with Office of the Insurance Commissioner Regulations

The Contractor shall comply with all Office of the Insurance Commissioner (OIC) regulations regarding utilization management and authorization of services unless those regulations are in direct conflict with Federal regulations. Where it is necessary to harmonize Federal and state regulations, HCA will direct such harmonization. If an OIC regulation changes during the Period of Performance of this Contract, HCA will determine whether and when to apply the regulation.

12 PROGRAM INTEGRITY

12.1 General Requirements

12.1.1 The Contractor shall have and comply with policies and procedures that guide and require the Contractor and the Contractor's officers, employees, agents and subcontractors compliance with the requirements of this section.

12.1.2 The Contractor shall include Program Integrity requirements in its subcontracts and provider application, credentialing and recredentialing processes.

12.1.3 The following are relevant citations for Program Integrity compliance. The Contractor is expected to be familiar with, comply with, and require compliance with all regulations related to Program Integrity whether or not those regulations are listed.

12.1.3.1 Section 1902(a)(68) of the Social Security Act

12.1.3.2 42 C.F.R. § 438.610

12.1.3.3 42 C.F.R. § 455

12.1.3.4 42 C.F.R. § 1000 through 1008

12.1.3.5 Chapter 182-502A WAC

12.2 Program Integrity

The Contractor shall ensure compliance with the program integrity provisions of this Contract, including proper payments to providers or subcontractors and methods for detection of fraud, waste, and abuse.

12.2.1 The Contractor shall have a staff person dedicated to working collaboratively with HCA on program integrity issues. This will include the following:

12.2.1.1 Participation in MCO-specific, quarterly program integrity meetings with HCA following the submission of the quarterly allegation log defined in Subsection 12.9, Reporting, of this Contract. Discussion at these meetings shall include but not be limited to case

development and monitoring.

12.2.1.2 Participation in a bi-annual Contractor-wide forum to discuss best practices, performance metrics, provider risk assessments, analytics, and lessons learned.

12.2.1.3 Quality control and review of encounter data submitted to HCA.

12.2.2 The Contractor shall perform ongoing analysis of its utilization, claims, billing, and/or encounter data to detect overpayments, and shall perform audits and investigations of subcontractor providers and provider entities. This may include audits against all State-funded claims including Medicaid, CHIP, and Basic Health Plan. For the purposes of this subsection, "overpayment" means a payment from the Contractor to a subcontractor to which the subcontractor is not entitled to by law, rule, or contract, including amounts in dispute.

12.2.2.1 When the Contractor or the State identifies an overpayment, it will be considered an obligation, as defined at RCW 74.09.220, and the funds must be recovered by and/or returned to the State or the Contractor.

12.2.2.2 To maintain compliance with regulations found in Section 1128J(d) of the Social Security Act, overpayments that are not recovered by or returned to the Contractor within sixty (60) calendar days from the date they were identified and known by the State and/or the Contractor, such overpayments may be recovered by HCA.

12.2.2.3 Consistent with subsection 12.9.3 of this Contract, the Contractor shall submit quarterly reports of any recoveries made by the Contractor during the course of its claims review/analysis.

12.3 **Disclosure by Managed Care Organization: Information on Ownership and Control**

12.3.1 The Contractor must provide to HCA the following disclosures and must require its subcontractors to provide the same disclosures to the Contractor (42 C.F.R. § 455.104):

12.3.1.1 The name, address, sets of fingerprints in a form and manner to be determined by HCA, and financial statement(s) of any person (individual or corporation) that has five percent (5%) or more ownership or control interest in the Contractor.

12.3.1.2 The name and address of any person (individual or corporation) that has five percent (5%) or more ownership or control interest in the Contractor's subcontractor.

12.3.1.3 The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

12.3.1.4 Date of birth and Social Security Number (in the case of an

individual).

12.3.1.5 Other tax identification number (in the case of a corporation) with an ownership or control interest in the managed care organization or its subcontractor.

12.3.2 Whether the person (individual or corporation) with an ownership or control interest in the managed care organization is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the managed care organization has a five percent (5%) or more interest is related to another person with ownership or control interest in the managed care organization as a spouse, parent, child, or sibling.

12.3.3 The name of any other managed care organization in which an owner of the managed care organization has an ownership or control interest.

12.3.4 The name, address, date of birth, and Social Security Number of any managing employee of the managed care organization. For the purposes of this Subsection "managing employee" means a general manager, business manager, administrator, director (i.e. member of the board of directors), or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

12.3.5 The Contractor must terminate or deny enrollment if the provider, or any person with five percent (5%) or greater direct or indirect ownership interest in the provider, fails to submit sets of fingerprints in a form and manner to be determined by HCA within thirty (30) calendar days when requested by HCA or any authorized federal agency. (See 42 C.F.R. 455.416(e)).

12.3.6 Disclosures from the Contractor are due to HCA at any of the following times:

12.3.6.1 Upon the managed care organization submitting the proposal in accordance with HCA's procurement process.

12.3.6.2 Upon the managed care entity executing the Contract with HCA.

12.3.6.3 Upon renewal or extension of the Contract.

12.3.6.4 Within thirty-five (35) calendar days after any change in ownership of the managed care entity.

12.3.6.5 Upon request by HCA.

12.4 **Disclosure by Managed Care Organization: Information on Ownership and Control, Subcontractors and Providers**

12.4.1 The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

12.4.1.1 Requiring the subcontractor or provider to disclose to HCA upon contract execution [42 C.F.R. 455.104(c)(1)(ii)], upon request during the re-validation of enrollment process under 42 C.F.R. 455.414 [42 C.F.R. 455.104(c)(1)(iii)], and within thirty-five (35) business days after any change in ownership of the subcontractor or provider 42 C.F.R. 455.104(c)(1)(iv).

12.4.1.2 The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor or provider. 42 C.F.R. 455.104(b)(1)(i).

12.4.1.3 If the subcontractor or provider is a corporate entity, the disclosure must include primary business address, every business location, and P.O. Box address. 42 C.F.R. 455.104(b)(1)(i).

12.4.1.4 If the subcontractor or provider has corporate ownership, the tax identification number of the corporate owner(s). 42 C.F.R. 455.104(b)(1)(iii).

12.4.1.5 If the subcontractor or provider is an individual, date of birth and Social Security Number. 42 C.F.R. 455.104(b)(1)(ii).

12.4.1.6 If the subcontractor or provider has a five percent (5%) ownership interest in any of its subcontractors, the tax identification number of the subcontractor(s). 42 C.F.R. 455.104(b)(1)(iii).

12.4.1.7 Whether any person with an ownership or control interest in the subcontractor or provider is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor/provider. 42 C.F.R. 455.104(b)(2).

12.4.1.8 If the subcontractor or provider has a five percent (5%) ownership interest in any of its subcontractors, whether any person with an ownership or control interest in such subcontractor is related by marriage or blood as a spouse, parent, child, or sibling to any other person with an ownership or control interest in the subcontractor or provider. 42 C.F.R. 455.104(b)(2).

12.4.1.9 Whether any person with an ownership or control interest in the subcontractor/provider also has an ownership or control interest in any other Medicaid provider, in the state's fiscal provider or in any managed care entity. 42 C.F.R. 455.104(b)(4).

12.5 **Information on Persons Convicted of Crimes**

The Contractor shall include the following provisions in its written agreements with all subcontractors and providers who are not individual practitioners or a group of practitioners:

12.5.1 Requiring the subcontractor/provider to investigate and disclose to HCA, at contract execution or renewal, and upon request of HCA the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs and who is [42 C.F.R. 455.106(a)]:

12.5.1.1 A person who has an ownership or control interest in the subcontractor or provider. 42 C.F.R. 455.106(a)(1).

12.5.1.2 An agent or person who has been delegated the authority to obligate or act on behalf of the subcontractor or provider. 42 C.F.R. 455.101; 42 C.F.R. 455.106(a)(1).

12.5.1.3 An agent, managing employee, general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of, the subcontractor or provider. 42 C.F.R. 455.101; 42 C.F.R. 455.106(a)(2).

12.6 **Fraud and Abuse**

The Contractor's Fraud and Abuse program shall have:

12.6.1 A process to inform officers, employees, agents and subcontractors regarding the False Claims Act.

12.6.2 Administrative and management arrangements or procedures, and a mandatory compliance plan.

12.6.3 Standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and state standards.

12.6.4 The designation of a compliance officer and a compliance committee that is accountable to senior management.

12.6.5 Effective training for all affected parties.

12.6.6 Effective lines of communication between the compliance officer and the Contractor's staff and subcontractors.

12.6.7 Enforcement of standards through well-publicized disciplinary guidelines.

12.6.8 Provision for internal monitoring and auditing.

12.6.9 Provision for prompt response to detected offenses, and for development of corrective action initiatives.

12.6.10 Provision of detailed information to employees and subcontractors regarding fraud and abuse policies and procedures and the False Claims Act as identified in Section 1902(a)(68) of the Social Security Act and the Washington false claims statutes, Chapter 74.66 RCW and RCW 74.09.210.

12.6.11 Provision for full cooperation with any federal, HCA or Attorney General Medicaid

Fraud Control Unit (MFCU) investigation including promptly supplying all data and information requested for the investigation.

12.6.12 Verification that services billed by providers were actually provided to enrollees. The Contractor may use explanation of benefits (EOB) for such verification only if the Contractor suppresses EOBs that would be a violation of enrollee confidentiality requirements for women's healthcare, family planning, sexually transmitted diseases, and behavioral health services (42 C.F.R. § 455.20).

12.7 Referrals of Credible Allegations of Fraud and Provider Payment Suspensions

The Contractor shall establish policies and procedures for MFCU referrals on credible allegations of fraud and for payment suspension when the Contractor determines there is a credible allegation of fraud.(42 C.F.R § 455.23).

12.7.1 When the Contractor has concluded that a credible allegation of fraud has occurred, the Contractor shall make a fraud referral to MFCU and HCA within five (5) business days of the determination. The referral must be in writing and sent to MFCUreferrals@atg.wa.gov with copies to HotTips@hca.wa.gov and the managed care mail box (hcamcprograms@hca.wa.gov). The referral must include the following information:

12.7.1.1 The reporter's full name, company and contact information, to include, telephone number, electronic mail address and mailing address;

12.7.1.2 Subject(s) of the complaint by name and either subject/subcontractor type or employee position;

12.7.1.3 Whether the subject is subcontracted with the Contractor;

12.7.1.4 Source of complaint by name and subject/subcontractor type or employee position, if applicable;

12.7.1.5 Nature of the complaint;

12.7.1.6 Estimate of the amount of funds involved;

12.7.1.7 Indicate whether a good cause exception is requested and the grounds for the exception;

12.7.1.8 Include a recommendation of whether or not a payment suspension should occur, in whole or in part; and

12.7.1.9 Legal and administrative disposition of the case.

12.7.2 If HCA, the Medicaid Fraud Control Unit (MFCU) or other law enforcement agency accepts the allegation for investigation, HCA shall notify the Contractor's compliance officers within two (2) business days of acceptance notification, along with a directive to suspend payment to the affected provider(s) if it is determined

that suspension will not impair MFCU's or law enforcement's investigation. HCA shall notify the Contractor if the referral is declined for investigation. If HCA, MFCU, or other law enforcement agencies decline to investigate the fraud referral, the Contractor may proceed with its own investigation and comply with the reporting requirements contained in this Subsection 12.7.

12.7.3 Upon receipt of notification from HCA, the Contractor shall send notice of the decision to suspend program payments to the provider within the following timeframes:

12.7.3.1 Within five (5) calendar days of taking such action unless requested in writing by HCA, the Medicaid Fraud Control Unit (MFCU), or law enforcement agency to temporarily withhold such notice.

12.7.3.2 Within thirty (30) calendar days if requested by HCA, MFCU, or law enforcement in writing to delay sending such notice. The request for delay may be renewed in writing no more than twice and in no event may the delay exceed ninety (90) calendar days.

12.7.4 The notice must include or address all of the following (42 C.F.R. § 455.23(2):

12.7.4.1 State that payments are being suspended in accordance with this provision;

12.7.4.2 Set forth the general allegations as to the nature of the suspension action. The notice need not disclose any specific information concerning an ongoing investigation;

12.7.4.3 State that the suspension is for a temporary period and cite the circumstances under which the suspension will be lifted;

12.7.4.4 Specify, when applicable, to which type or types of claims or business units the payment suspension relates; and

12.7.4.5 Where applicable and appropriate, Inform the provider of any appeal rights available to this provider, along with the provider's right to submit written evidence for consideration by the Contractor.

12.7.5 All suspension of payment actions under this section will be temporary and will not continue after either of the following:

12.7.5.1 It is determined by HCA, MFCU, or law enforcement that there is insufficient evidence of fraud by the provider; or

12.7.5.2 Legal proceedings related to the provider's alleged fraud are completed and the allegation of fraud was not upheld.

12.7.6 The Contractor must document in writing the termination of a suspension.

12.7.7 The Contractor and/or HCA may find that good cause exists not to suspend payments, in whole or in part, or not to continue a payment suspension

previously imposed, to an individual or entity against which there is an investigation of a credible allegation of fraud if any of the following are applicable:

12.7.7.1 MFCU or other law enforcement officials have specifically requested that a payment suspension not be imposed because such a payment suspension may compromise or jeopardize an investigation.

12.7.7.2 Other available remedies are implemented by the Contractor, after HCA approves remedy, that more effectively or quickly protect Medicaid funds.

12.7.7.3 The Contractor determines, based upon the submission of written evidence by the individual or entity that is the subject of the payment suspension, there is no longer a credible allegation of fraud and that the suspension should be removed. The Contractor shall review evidence submitted by the provider and submit it with a recommendation to HCA. HCA shall direct the Contractor to continue, reduce or remove the payment suspension within thirty (30) calendar days of having received the evidence.

12.7.7.4 Enrollee access to items or services would be jeopardized by a payment suspension because of either of the following:

12.7.7.4.1 An individual or entity is the sole community physician or the sole source of essential specialized services in a community.

12.7.7.4.2 The individual or entity serves a large number of enrollees within a federal Health Resources and Services Administration (HRSA) designated medically underserved area.

12.7.7.5 MFCU or law enforcement declines to certify that a matter continues to be under investigation.

12.7.7.6 HCA determines that payment suspension is not in the best interests of the Medicaid program.

12.7.8 The Contractor shall maintain for a minimum of six (6) years from the date of issuance all materials documenting:

12.7.8.1 Details of payment suspensions that were imposed in whole or in part;

12.7.8.2 Each instance when a payment suspension was not imposed or was discontinued for good cause.

12.7.9 If the Contractor fails to suspend payments to an entity or individual for whom there is a pending investigation of a credible allegation of fraud without good

cause, and HCA directed the Contractor to suspend payments, HCA may impose sanctions in accord with the Sanctions Subsection of this Contract.

12.7.10 If any government entity, either from restitutions, recoveries, penalties or fines imposed following a criminal prosecution or guilty plea, or through a civil settlement or judgment, or any other form of civil action, receives a monetary recovery from any entity, the entirety of such monetary recovery belongs exclusively to the State of Washington and the Contractor has no claim to any portion of this recovery.

12.7.11 Furthermore, the Contractor is fully subrogated, and shall require its subcontractors to agree to subrogate, to the State of Washington for all criminal, civil and administrative action recoveries undertaken by any government entity, including, but not limited to, all claims the Contractor or subcontractor has or may have against any entity that directly or indirectly receives funds under this Contract including, but not limited to, any health care provider, manufacturer, wholesale or retail supplier, sales representative, laboratory, or other provider in the design, manufacture, marketing, pricing, or quality of drugs, pharmaceuticals, medical supplies, medical devices, durable medical equipment, or other health care related products or services.

12.7.12 Any funds recovered and retained by a government entity will be reported to the actuary to consider in the rate-setting process.

12.7.13 For the purposes of this Section, “subrogation” means the right of any State of Washington government entity or local law enforcement to stand in the place of a Contractor or client in the collection against a third party..

12.8 **Excluded Individuals and Entities**

The Contractor is prohibited from paying with funds received under this Contract for goods and services furnished by an excluded person, at the medical direction or on the prescription of an excluded person (Social Security Act (SSA) section 1903(i)(2) of the Act; 42 C.F.R. § 455.104, 42 C.F.R. § 455.106, and 42 C.F.R. § 1001.1901(b)).

12.8.1 The Contractor shall monitor for excluded individuals and entities by:

12.8.1.1 Screening Contractor and subcontractor individuals and entities with an ownership or control interest during the initial provider application, credentialing and recredentialing processes and prior to entering into a contractual or other relationship where the individual or entity would benefit directly or indirectly from funds received under this Contract and payable by a federal health care program.

12.8.1.2 Screening individuals during the initial provider application, credentialing and recredentialing process and before entering into a contractual or other relationship where the individual would benefit directly or indirectly from funds received under this Contract or payable by a federal health care program.

12.8.1.3 Screen, the LEIE and SAM lists monthly on the 15th of each month, all Contractor and subcontractor individuals and entities with an

ownership or control interest, individuals defined as affiliates, as defined in the Federal Acquisition Regulation, of a person described in paragraph (a)(1), and individuals that would benefit from funds received under this Contract for newly added excluded individuals and entities. 42 C.F.R. 438.610(a), 42 C.F.R. 438.610(b), SMD letter 2/20/98).

12.8.2 The Contractor will not make any payments for goods or services that directly or indirectly benefit any excluded individual or entity effective with the date of exclusion. The Contractor will immediately recover any payments for goods and services that benefit excluded individuals and entities that it discovers.

12.8.3 The Contractor shall immediately terminate any employment, contractual and control relationships with any excluded individual or entity discovered during its provider screening processes, including the provider application, credentialing and recredentialing, and shall report these individuals and entities within ten (10) business days of discovery.

12.8.4 Civil monetary penalties may be imposed against the Contractor if it employs or enters into a contract with an excluded individual or entity to provide goods or services to enrollees. (SSA section 1128A(a)(6) and 42 C.F.R. § 1003.102(a)(2)).

12.8.5 An individual or entity is considered to have an ownership or control interest if they have direct or indirect ownership of 5 percent or more, or are a managing employee (e.g., a general manager, business manager, administrator, or director) who exercises operational or managerial control, or who directly or indirectly conducts day-to-day operations (SSA section 1126(b), 42 C.F.R. § 455.104(a), and 42 C.F.R. § 1001.1001(a)(1)).

12.8.6 In addition, if HCA notifies the Contractor that an individual or entity is excluded from participation by HCA, the Contractor shall terminate all beneficial, employment, and contractual and control relationships with the excluded individual or entity immediately (WAC 182-502-0030).

12.8.7 The HCA will validate that the Contractor is conducting all screenings required by this Section during its annual monitoring review.

12.9 **Reporting**

12.9.1 All Program Integrity reporting to HCA shall be in accord with the Notices provisions of the General Terms and Conditions of this Contract unless otherwise specified herein.

12.9.2 Quarterly Allegation Log: Notwithstanding the obligation to report suspicions of fraud directly to MFCU and HCA as required under 12.9.1 of this Section, on a quarterly basis (the first week of April, July, October, and January) the Contractor shall submit to HCA in a format determined by HCA, a report of all allegations of fraud received and reviewed by the Contractor during the previous quarter. The report shall include:

12.9.2.1 All cases being actively pursued by the Contractor;

12.9.2.2 All cases that did not warrant opening a case for investigation; and

12.9.2.3 All allegations that were reported to the Office of the Attorney General, Medicaid Fraud Control Unit.

12.9.2.4 This report shall contain the following information for each case described above, submitted on a template provided by HCA:

12.9.2.4.1 Date complaint or referral received;

12.9.2.4.2 Date the complaint was opened as a case;

12.9.2.4.3 Last date case was updated with additional information;

12.9.2.4.4 Subject(s) of complaint by name and provider/subcontractor type, member or employee position;

12.9.2.4.5 Source of complaint (i.e., provider/subcontractor type, member, employee, vendor, hotline call, etc.), if applicable;

12.9.2.4.6 Nature of complaint;

12.9.2.4.7 Estimate of the amount of funds involved;

12.9.2.4.8 Legal and administrative disposition of the case; and

12.9.2.4.9 If actual recoveries were made by the Contractor as the result of the investigation.

12.9.3 On a quarterly basis, the Contractor shall submit to HCA, on an HCA generated reporting format, a report of any recoveries made, or overpayments identified by the Contractor during the course of their claims review/analysis.

12.9.4 On an annual basis, the Contractor shall report to HCA summary information on each of the following:

12.9.4.1 Suspension of payment, including the nature of the suspected fraud, the basis for suspension, any known progress on the investigation, date the suspension was implemented, the outcome of the suspension, and total amount being withheld, if any, from the provider.

12.9.4.2 Situations in which the Contractor determined good cause existed to not suspend payments, to suspend payments only in part, or to discontinue a payment suspension as described in this section, including describing the nature of the suspected fraud and the nature of the good cause.

12.9.4.3 The Contractor is responsible for investigating enrollee fraud, waste and abuse. The Contractor shall provide a report of initial allegations, investigations and resolutions of enrollee fraud, waste and abuse to HCA during the annual monitoring review.

12.9.5 The Contractor shall notify the Washington State Department of Social and Health Services (DSHS) Office of Fraud and Accountability (OFA) of any cases in which the Contractor believes there is a serious likelihood of enrollee fraud by:

12.9.5.1 Calling the Welfare Fraud Hotline at 1-800-562-6906 and pressing option ”1” to report Welfare Fraud by leaving a detailed voice mail message;

12.9.5.2 Mailing a written complaint to:

Welfare Fraud Hotline
P.O. Box 45817
Olympia, WA 98504-5817

12.9.5.3 Entering the complaint online at: https://fortress.wa.gov/dshs/dshsroot/fraud/index.asp;

12.9.5.4 Faxing the written complaint to Attention Hotline at 360-664-0032; OR

12.9.5.5 Emailing the compliant electronically to the DSHS OFA Hotline at Hotline@dshs.wa.gov.

12.9.6 Any excluded individuals and entities discovered in the screening described in the Fraud and Abuse Subsection of this Contract, including the provider application, credentialing and recredentialing processes, must be reported to HCA within ten (10) business days of discovery. HCA will provide a template for the report by January 30. 2015.

12.9.7 The Contractor shall investigate and disclose to HCA, at contract execution or renewal, and upon request of HCA, the identity of any person who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XXI services program since the inception of those programs and who is an agent or person who has been delegated the authority to obligate or act on behalf of the Contractor.

12.9.8 The Contractor shall submit to HCA a monthly report on the fifteenth of each month of identified excluded individuals/entities that have been reported on the HHS-OIG LEIE and the SAM.

12.9.9 The Contractor shall submit to HCA a monthly List of Involuntary Terminations Report including providers terminated due to sanction, invalid licenses, services, billing, data mining, investigation and any related program integrity involuntary termination. The Contractor shall send the report electronically to HCA at hcamcprograms@hca.wa.gov with subject “Program Integrity Monthly list of

Involuntary Terminations Report." The report must include all of the following:

12.9.9.1 Individual provider/entities' name;

12.9.9.2 Individual provider/entities' NPI number;

12.9.9.3 Source of involuntary termination;

12.9.9.4 Nature of the involuntary termination; and

12.9.9.5 Legal action against the individual/entities.

12.9.10 Upon request, the Contractor and the Contractor's subcontractors shall furnish to HCA, within thirty-five (35) calendar days of the request, full and complete business transaction information as follows:

12.9.10.1 The ownership of any subcontractor with whom the Contractor or subcontractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

12.9.10.2 Any significant business transactions between the Contractor or subcontractor and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

12.9.11 Upon request the Contractor and the Contractor's subcontractors shall furnish to the Washington Secretary of State, OIG, the US Treasury Office of the Comptroller, and to HCA a description of the transaction between the Contractor and the other party of interest within thirty-five (35) calendar days of the request, including the following transactions 42 C.F.R. 438.50(c)(1):

12.9.11.1 A description of transactions between the Contractor and a party in interest (as defined in section 1318(b) of the Public Health Service Act), including the following:

12.9.11.1.1 Any sale or exchange, or leasing of any property between the Contractor and such a party.

12.9.11.1.2 Any furnishing for consideration of goods, services (including management services), or facilities between the Contractor and such a party but not including salaries paid to employees for services provided in the normal course of their employment.

12.9.11.1.3 Any lending of money or other extension of credit between the Contractor and such a party. (1903(m)(4)(B); 42 C.F.R. 438.50(c)(1)).

12.10 **Records Requests**

12.10.1 Upon request the Contractor and the Contractor's subcontractors shall give HCA or any authorized state or federal agency or authorized representative, access to all records pertaining to this Contract, including computerized data stored by the Contractor or subcontractor. The Contractor and its subcontractors shall provide the records at no cost to the requesting agency. (42 C.F.R. 455.21(a)(2); 42 C.F.R. 431.107(b)(2)).

12.10.2 The Contractor or subcontractor shall furnish all records pertaining to this Contract upon request.

12.11 **On-Site Inspections**

12.11.1 The Contractor and its subcontractors must provide any record or data pertaining to this Contract including, but not limited to:

12.11.1.1 Medical records;

12.11.1.2 Billing records;

12.11.1.3 Financial records;

12.11.1.4 Any record related to services rendered, quality, appropriateness, and timeliness of service; and

12.11.1.5 Any record relevant to an administrative, civil or criminal investigation or prosecution.

12.11.2 If these records must be evaluated, inspected, or reviewed, the Contractor or subcontractor shall immediately provide the records.

12.11.3 Upon request, the Contractor or subcontractor shall assist in such review, including the provision of complete copies of records.

12.11.4 The Contractor must provide access to its premises and the records requested for inspection, evaluation, review to any, state or federal agency or entity, including, but not limited to: HCA, CMS, OIG, MFCU, Office of the Comptroller of the Treasury, whether the visitation is announced or unannounced**.**

13 GRIEVANCE SYSTEM

13.1 **General Requirements**

The Contractor shall have a grievance system which complies with the requirements of 42 C.F.R. § 438 Subpart F and Chapters 182-538, 182-526, and 284-43 WAC, insofar as those WACs are not in conflict with 42 C.F.R. § 438 Subpart F. The grievance system shall include a grievance process, an appeal process, access to independent review, and

access to the hearing process. NOTE: Provider claim disputes initiated by the provider are not subject to this Section.

13.1.1 The Contractor shall have policies and procedures addressing the grievance system, which comply with the requirements of this Contract. HCA must approve, in writing, all grievance system policies and procedures and related notices to enrollees regarding the grievance system.

13.1.2 The Contractor shall give enrollees any reasonable assistance necessary in completing forms and other procedural steps for grievances and appeals (42 C.F.R. § 438.406(a)(1) and WAC 284-43-615(2)(d)).

13.1.3 The Contractor shall acknowledge receipt of each grievance, either orally or in writing, within two (2) business days.

13.1.4 The Contract shall acknowledge in writing, the receipt of each appeal. The Contractor shall provide the written notice to both the enrollee and requesting provider within seventy-two (72) hours of receipt of the appeal. (42 C.F.R. § 438.406(a)(2) and (WAC 284-43-620).

13.1.5 The Contractor shall ensure that decision makers on grievances and appeals were not involved in previous levels of review or decision-making (42 C.F.R. § 438.406(a)(3)(i)).

13.1.6 A physician, doctoral level psychologist, certified addiction medicine specialist, or pharmacist, as appropriate, shall review any behavioral health appeal of care based on medical necessity.

13.1.7 Decisions regarding grievances and appeals shall be made by health care professionals with clinical expertise in treating the enrollee's condition or disease if any of the following apply (42 C.F.R. § 438.406(a)(3)(ii)):

13.1.7.1 If the enrollee is appealing an action concerning medical necessity.

13.1.7.2 If an enrollee grievance concerns a denial of expedited resolution of an appeal.

13.1.7.3 If the grievance or appeal involves any clinical issues.

13.2 **Grievance Process**

The following requirements are specific to the grievance process:

13.2.1 Only an enrollee or the enrollee's authorized representative may file a grievance with the Contractor; a provider may not file a grievance on behalf of an enrollee (42 C.F.R. § 438.402(b)(3)) unless the provider is acting on behalf of the enrollee and with the enrollee's written consent.

13.2.2 The Contractor shall accept, document, record, and process grievances forwarded by HCA. The Contractor shall provide a written response to HCA within three (3) business days to any constituent grievance. For the purpose of this subsection, "constituent grievance" means a complaint or request for

information from any elected official or agency director or designee.

13.2.3 The Contractor shall assist the enrollee with all grievance and appeal processes (WAC 284-43-615(2)(d)).

13.2.4 The Contractor shall cooperate with any representative authorized in writing by the covered enrollee (WAC 284-43-615(2)(e)).

13.2.5 The Contractor shall consider all information submitted by the covered person or representative (WAC 284-43-615(2)(f)).

13.2.6 The Contractor shall investigate and resolve all grievances whether received orally or in writing (WAC 284-43-615(2)(g)). The Contractor shall not require an enrollee or his/her authorized representative to provide written follow-up for a grievance or appeal the Contractor received orally.

13.2.7 The Contractor shall complete the disposition of a grievance and notice to the affected parties as expeditiously as the enrollee's health condition requires, but no later than forty-five (45) calendar days from receipt of the grievance.

13.2.8 The Contractor shall provide information on the covered person's right to obtain a second opinion (WAC 284-43-615(2(h)).

13.2.9 The Contractor must notify enrollees of the disposition of grievances within five (5) business days of determination. The notification may be orally or in writing for grievances not involving clinical issues. Notices of disposition for clinical issues must be in writing.

13.2.10 Enrollees do not have the right to a hearing in regard to the disposition of a grievance.

13.3 **Appeal Process**

The following requirements are specific to the appeal process:

13.3.1 An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee and with the enrollee's written consent, may appeal a Contractor action (42 C.F.R. § 438.402(b)(1)(ii)). For expedited appeals, the Contractor may bypass the requirement for enrollee written consent and obtain enrollee oral consent. The enrollee's oral consent shall be documented in the Contractor's UMP records.

13.3.2 If HCA receives a request to appeal an action of the Contractor, HCA will forward relevant information to the Contractor and the Contractor will contact the enrollee.

13.3.3 For appeals of standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety (90) calendar days of the date on the Contractor's notice of action. This also applies to an enrollee's request for an expedited appeal (42 C.F.R. § 438.402(b)(2) and WAC 182-538-110).

13.3.4 For appeals for termination, suspension, or reduction of previously authorized services when the enrollee requests continuation of such services, an enrollee must file an appeal within ten (10) calendar days of the date of the Contractor's mailing of the notice of action. If the enrollee is notified in a timely manner and

the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for appeals of standard resolution apply (42 C.F.R. § 438.420 and WAC 182-538-110).

13.3.5 Oral inquiries seeking to appeal an action shall be treated as appeals and be confirmed in writing, unless the enrollee or provider requests an expedited resolution (42 C.F.R. § 438.406(b)(1)). The appeal acknowledgement letter sent by the MCO to an enrollee shall serve as written confirmation of an appeal filed orally by an enrollee.

13.3.6 The appeal process shall provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The Contractor shall inform the enrollee of the limited time available for this in the case of expedited resolution (42 C.F.R. § 438.406(b)(2)).

13.3.7 The appeal process shall provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process (42 C.F.R. § 438.406(b)(3)).

13.3.8 The appeal process shall include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate (42 C.F.R. § 438.406(b)(4)).

13.3.9 In any appeal of an action by a subcontractor, the Contractor or its subcontractor shall apply the Contractor's own clinical practice guidelines, standards, protocols, or other criteria that pertain to authorizing specific services.

13.3.10 The Contractor shall resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following timeframes (42 C.F.R. § 438.408(b)(2)-(3)):

13.3.10.1 For standard resolution of appeals and for appeals for termination, suspension or reduction of previously authorized services a decision must be made within fourteen (14) calendar days after receipt of the appeal, unless the Contractor notifies the enrollee that an extension is necessary to complete the appeal; however, the extension cannot delay the decision beyond twenty-eight (28) calendar days of the request for appeal, without the informed written consent of the enrollee. In all circumstances the appeal determination must not be extended beyond forty-five (45) calendar days from the day the Contractor receives the appeal request.

13.3.10.2 For any extension not requested by an enrollee, the Contractor must give the enrollee written notice of the reason for the delay.

13.3.10.3 For expedited resolution of appeals or appeals of mental health drug authorization decisions, including notice to the affected parties, no longer than three (3) calendar days after the Contractor receives the appeal.

13.3.11 The notice of the resolution of the appeal shall:

13.3.11.1 Be in writing and sent to the enrollee and the requesting provider. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice (42 C.F.R. § 438.408(d)).

13.3.11.2 Include the date completed and reasons for the determination in easily understood language (42 C.F.R. § 438.408(e)).

13.3.11.3 Include a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the UMP clinical review or decision-making criteria.

13.3.11.4 For appeals not resolved wholly in favor of the enrollee (42 C.F.R. § 438.408(e)(2)):

13.3.11.4.1 Include information on the enrollee's right to request a hearing and how to do so.

13.3.11.4.2 Include information on the enrollee's right to receive services while the hearing is pending and how to make the request.

13.3.11.4.3 Inform the enrollee that the enrollee may be held liable for the amount the Contractor pays for services received while the hearing is pending, if the hearing decision upholds the Contractor's action.

13.4 **Expedited Appeal Process**

13.4.1 The Contractor shall establish and maintain an expedited appeal review process for appeals when the Contractor determines or a provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function (42 C.F.R. § 438.410(a)).

13.4.2 The enrollee may file an expedited appeal either orally or in writing. No additional enrollee follow-up is required.

13.4.3 The Contractor shall make a decision on the enrollee's request for expedited appeal and provide written notice, as expeditiously as the enrollee's health condition requires, within three (3) calendar days after the Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3)). The Contractor shall also make reasonable efforts to provide oral notice.

13.4.4 The Contractor may extend the timeframes by up to fourteen (14) calendar days if the enrollee requests the extension; or the Contractor shows there is a need for additional information and how the delay is in the enrollee's interest.

13.4.5 For any extension not requested by an enrollee, the Contractor must give the enrollee written notice of the reason for the delay.

13.4.6 The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal (42 C.F.R.

§ 438.410(b)).

13.4.7 If the Contractor denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution and make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice (42 C.F.R. § 438.410(c)).

13.4.8 The enrollee has a right to file a grievance regarding the Contractor's denial of a request for expedited resolution. The Contractor must inform the enrollee of their right to file a grievance in the notice of denial.

13.5 **Administrative Hearing**

13.5.1 Only the enrollee or the enrollee's authorized representative may request a hearing. A provider may not request a hearing on behalf of an enrollee.

13.5.2 If an enrollee does not agree with the Contractor's resolution of the appeal, the enrollee may file a request for a hearing within the following time frames (See WAC 182-526-0200):

13.5.2.1 For hearings regarding a standard service, within ninety (90) calendar days of the date of the notice of the resolution of the appeal (42 C.F.R. § 438.402(b)(2)).

13.5.2.2 For hearings regarding termination, suspension, or reduction of a previously authorized service, if the enrollee requests continuation of services, within ten (10) calendar days of the date on the Contractor's mailing of the notice of the resolution of the appeal. If the enrollee is notified in a timely manner and the enrollee's request for continuation of services is not timely, the Contractor is not obligated to continue services and the timeframes for a hearing regarding a standard service apply (42 C.F.R. § 438.420).

13.5.3 If the enrollee requests a hearing, the Contractor shall provide to HCA and the enrollee, upon request, and within three (3) working days, and for expedited appeals, within one (1) working day, all Contractor-held documentation related to the appeal, including but not limited to, any transcript(s), records, or written decision(s) from participating providers or delegated entities.

13.5.4 The Contractor is an independent party and is responsible for its own representation in any hearing, independent review, Board of Appeals and subsequent judicial proceedings.

13.5.5 The Contractor's medical director or designee shall review all cases where a hearing is requested and any related appeals, when medical necessity is an issue.

13.5.6 The enrollee must exhaust all levels of resolution and appeal within the Contractor's grievance system prior to filing a request for a hearing with HCA.

13.5.7 HCA will notify the Contractor of hearing determinations. The Contractor will be bound by the final order, whether or not the final order upholds the Contractor's decision. Implementation of the final order shall not be the basis for termination

of enrollment by the Contractor.

13.5.8 If the final order is not within the purview of this Contract, then HCA will be responsible for the implementation of the final order.

13.5.9 The hearings process shall include as parties to the hearing, the Contractor, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate and HCA.

13.6 **Independent Review**

After exhausting both the Contractor's appeal process and the administrative hearing, an enrollee has a right to request an independent review in accord with RCW 48.43.535, WAC 182-526-0200, and Chapter 284-43 WAC. Independent review is at the option of the enrollee but is not a prerequisite for filing a Petition for Review at HCA's Board of Appeals.

13.7 **Petition for Review**

Any party may appeal the initial order from the administrative hearing to HCA Board of Appeals in accord with Chapter 182-526 WAC. Notice of this right shall be included in the Initial Order from the administrative hearing or the written decision of the Independent Review Organization.

13.8 **Continuation of Services**

13.8.1 The Contractor shall continue the enrollee's services if all of the following apply (42 C.F.R. § 438.420):

13.8.1.1 An appeal, hearing, or independent review is requested on or before the later of the following:

13.8.1.1.1 Within ten (10) calendar days of the Contractor mailing the notice of action, which for actions involving services previously authorized, shall be delivered by a method that certifies receipt and assures delivery within three (3) calendar days.

13.8.1.1.2 The intended effective date of the Contractor's proposed action.

13.8.1.2 The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment.

13.8.1.3 The original period covered by the original authorization has not expired.

13.8.1.4 The enrollee requests an extension of services.

13.8.2 If, at the enrollee's request, the Contractor continues or reinstates the enrollee's services while the appeal, hearing, or independent review is pending, the services shall be continued until one of the following occurs (42 C.F.R. § § 438.420 and WAC 182-526-0200 and WAC 182-538-110):

13.8.2.1 The enrollee withdraws the appeal, hearing, or independent review request.

13.8.2.2 Ten (10) calendar days pass after the Contractor mails the notice of the resolution of the appeal and the enrollee has not requested a hearing (with continuation of services until the hearing decision is reached) within the ten (10) calendar days.

13.8.2.3 The time period or service limits of a previously authorized service has been met.

13.8.2.4 When the Office of Administrative Hearings issues a decision adverse to the enrollee.

13.8.3 If the final resolution of the appeal upholds the Contractor's action, the Contractor may recover from the enrollee the amount paid for the services provided to the enrollee for the first sixty (60) calendar days during which the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

13.9 Effect of Reversed Resolutions of Appeals and Hearings

13.9.1 If the Contractor, or through a final order of the Office of Administrative Hearings (OAH) or Board of Appeals (BOA), or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires (42 C.F.R. § 438.424(a)).

13.9.2 If the Contractor, or through a final order of OAH or the Board of Appeals, or an IRO reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the Contractor shall pay for those services. (42 C.F.R. § 438.424(b)).

13.10 Recording and Reporting Actions, Grievances, Appeals and Independent Reviews

The Contractor shall maintain records of all actions, grievances, appeals and independent reviews.

13.10.1 The records shall include actions, grievances and appeals handled by delegated entities, and all documents generated or obtained by the Contractor in the course of responding to such actions, grievances, appeals, and independent reviews.

13.10.2 The Contractor shall provide a report of all actions, grievances, appeals and independent reviews to HCA in accord with the Grievance System Reporting Requirements published by HCA.

13.10.3 The Contractor is responsible for maintenance of records for and reporting of any grievance, actions, and appeals handled by delegated entities.

13.10.4 Delegated actions, grievances, and appeals are to be integrated into the Contractor's report.

13.10.5 Data shall be reported in HCA and Contractor agreed upon format. Reports that do not meet the Grievance System Reporting Requirements shall be returned to the Contractor for correction. Corrected reports will be resubmitted to HCA within 30 calendar days.

13.10.6 The report medium shall be specified by HCA and shall be in accord with the Grievance System Reporting Requirements published by HCA.

13.10.7 Reporting of actions shall include all denials or limited authorization of a requested service, including the type or level of service, and the reduction, suspension, or termination of a previously authorized service but will not include denials of payment to providers unless the enrollee is liable for payment in accord with WAC 182-502-0160 and the provisions of this Contract.

13.10.8 The Contractor shall provide information to HCA regarding denial of payment to providers upon request.

13.10.9 Reporting of grievances shall include all expressions of enrollee dissatisfaction not related to an action. All grievances are to be recorded and counted whether the grievance is remedied by the Contractor immediately or through its grievance and quality of care service procedures.

14 CARE COORDINATION

The Contractor shall provide the services described in this section for all enrollees who need care coordination, regardless of acuity level. The Contractor shall either provide the additional services described in Exhibit C, Health Homes to those enrollees who are determined eligible for Health Home or shall contract with a Qualified Health Home to provide such services.

14.1 Continuity of Care

The Contractor shall ensure Continuity of Care, as defined herein, for enrollees in an active course of treatment for a chronic or acute medical condition. The Contractor shall ensure that medically necessary care for enrollees is not interrupted and that transitions from one setting or level of care to another are promoted (42 C.F.R. § 438.208).

14.1.1 For changes in the Contractor's provider network or service areas, the Contractor shall comply with the notification requirements identified in the Service Area and Provider Network Changes provisions found in the Access to Care and Provider Network Section of this Contract.

14.1.2 If possible and reasonable, the Contractor shall preserve enrollee provider relationships through transitions.

14.1.3 Where preservation of provider relationships is not possible and reasonable, the Contractor shall provide transition to a provider who will provide equivalent, uninterrupted care as expeditiously as the enrollee's medical condition requires.

14.1.4 Unless otherwise required in this Contract to provide longer continuation of a prescribed medication, the Contractor shall allow new enrollees with the

Contractor to fill prescriptions written prior to enrollment until the first of the following occurs:

14.1.4.1 The enrollee's prescription expires. If the enrollee's prescription expires before he or she is able to be evaluated by a participating provider, the Contractor shall facilitate the receipt of a primary care visit and shall not deny the prescription.

14.1.4.2 A participating provider examines the enrollee to evaluate the continued need for the prescription, and if necessary, oversees medically appropriate changes that do not threaten the health of the enrollee.

14.1.4.2.1 If the enrollee refuses an evaluation by a participating provider the Contractor may refuse to cover the prescription as long as the enrollee's safety and the safety of others is considered in the decision.

14.1.4.3 The Contractor must approve payment for the dispensing of a refill of an antipsychotic, antidepressant, or antiepileptic medication without regard to length of enrollment or examination by a participating provider.

14.1.4.4 Allow enrollees to continue to receive care from non-participating providers with whom an enrollee has documented established relationships. The Contractor shall take the following steps:

14.1.4.4.1 The Contractor must make a good faith effort to subcontract with the established non-participating provider.

14.1.4.4.2 If transition is necessary, the Contractor shall facilitate collaboration between the established non-participating provider and the new participating provider to plan a safe, medically appropriate transition in care.

14.1.4.4.3 If the established non-participating provider or the enrollee will not cooperate with a necessary transition, the Contractor may transfer the enrollee's care to a participating provider within ninety (90) calendar days of the enrollee's enrollment effective date.

14.1.4.4.4 The Contractor may choose to pay the established non-participating provider indefinitely to provide care to the enrollee if the non-participating provider will accept payment rates the Contractor has established for non-participating providers as payment in full.

14.1.4.4.5 The Contractor shall apply utilization management decision-making standards to non-contracted providers

no more stringent than standards for participating providers.

14.2 **Identification of Individuals with Special Health Care Needs**

14.2.1 Within ninety (90) calendar days of enrollment, the Contractor shall identify every new individual with special health care needs whether or not the enrollee meets Health Home criteria.

14.2.1.1 To identify individuals with special health care needs, the Contractor may review administrative data, such as PRISM, diagnoses of acute conditions requiring care coordination services such as catastrophic injuries, children with elevated blood lead screen levels, chronic conditions, indicators of potential for high risk pregnancy, Foster Care, SSI or Title V designation, social complexity (history of homelessness, language barriers, diagnoses of substance use disorder or serious, persistent mental health conditions, domestic violence or arrests), enrollees with unmet care needs or evidence of being underserved or through enrollee responses to Contractor interviews or surveys.

14.2.2 On the 15th of the month following each quarter, the Contractor shall submit a report to HCA of individuals identified with special health care needs. The report shall include:

14.2.2.1 ProviderOne identifier;

14.2.2.2 Name (last, first, middle initial);

14.2.2.3 Birth date (xx/xx/xxxx);

14.2.2.4 Date of MCO enrollment;

14.2.2.5 Date of MCO identification of special needs designation;

14.2.2.6 Enrollee meets Health home criteria and agrees to participate (yes/no);

14.2.2.7 Enrollees who do not meet Health Home criteria referred to plan-based care coordination services (yes/no);

14.2.2.8 NPI of primary care provider (PCP);

14.2.2.9 Name of primary care provider PCP (last, first, middle); and

14.2.2.10 PCP credential (MD, DO, ARNP).

14.2.3 The Contractor shall facilitate referrals to the PCP, specialists, non-contracted services, such as substance use disorder programs, RSNs and community-based social services based on findings from enrollee identification.

14.2.4 The Contractor shall ensure that enrollee health information is shared between

MCOs and providers of its identification and assessment of any enrollee with special health care needs and in a manner that facilitates coordination of care while protecting confidentiality and enrollee privacy (42 C.F.R. § 438.208(b)(1-3) 438.208(b)(2)(4) and 45 C.F.R. § 160 and 164 subparts A and E).

14.3 **Care Coordination for Individuals with Special Health Care Needs**

The Contractor shall ensure that health care services are coordinated for all enrollees, including those not eligible for Health Home services as follows:

14.3.1 Initial Health Screen (IHS): The Contractor shall conduct an initial, brief health screen containing behavioral, developmental and physical and oral health questions within sixty (60) calendar days of enrollment for all new enrollees including family connects and reconnects. The Contractor is not required to screen enrollees who meet Health Home criteria.

14.3.2 The Contractor shall make at least three (3) reasonable attempts on different days and times of day to contact an enrollee to complete the IHS and document these attempts, for enrollees who are not referred for Health Home services. The requirements described in Exhibit C apply to enrollees who are referred for Health Home services.

14.3.3 Initial Health Assessment (IHA): To assess identified Individuals with Special Health Care Needs who are not eligible for Health Home services, the Contractor's care coordinator shall conduct an Initial Health Assessment (IHA) within sixty (60) calendar days of the identification of special needs or IHS that indicates the need for care coordination. The assessment shall determine ongoing need for care coordination services and the need for clinical and non-clinical services, including referrals to specialists and community resources.

14.3.3.1 The assessment shall include, at minimum, an evaluation of the enrollee's physical, behavioral, and oral health status, health services history, including receipt of preventive care services, current medications, and an evaluation of the need for or use of supportive services and resources, such as those described in the Coordination of Care provisions of this Contract.

14.3.3.2 The Contractor shall require the enrollee's primary care provider and care coordinator to ensure that arrangements are made for the enrollee to receive follow-up services that reflect the findings in the IHA, such as consultations with mental health and/or substance use disorder providers or referral to community-based social services.

14.3.3.3 The IHA shall be maintained in the enrollees' medical record and in the Contractor's care coordination file and available during subsequent preventive health visits.

14.3.4 The Contractor shall establish business rules, including policies and procedures regarding screening, referral and co-management of individuals with both behavioral health and physical health conditions. Both behavioral health and physical health care managers or Disease Management coaches will be trained on the protocols.

14.3.4.1 The Contractor shall require and ensure that primary care providers and care coordinators employed by the Contractor or in the Contractor's provider network shall be trained on standardized, validated screening tools used in the conduct of an IHA and an age appropriate evaluation, to evaluate at a minimum:

14.3.4.1.1 Delays in child development;

14.3.4.1.2 Behavioral health conditions including substance use disorders;

14.3.4.1.3 Adverse Childhood Experiences; and

14.3.4.1.4 Trauma-informed care.

14.3.4.2 The Contractor shall provide a toll free line for primary care providers and other medical specialists to call for technical and referral assistance when behavioral health conditions, requiring treatment or developmental delays are suspected or identified.

14.3.4.2.1 Available information shall include assistance in arranging for consultations, including mental health treatment referrals and substance use disorder treatment and treatment by providers with appropriate expertise and experience in mental health, substance use disorder or developmental issues.

14.3.4.2.2 Communication about the availability of this consultation service shall be found on the front-page of the Contractor's website and in materials supplied to Contracted providers.

14.3.5 The Contractor shall develop care coordination plan for individuals with special health care needs that do not meet Health Home referral criteria, so long as the following are true:

14.3.5.1 The enrollee is deemed appropriate for care management; and

14.3.5.2 The enrollee agrees to participate in care management.

14.3.6 The Contractor shall develop, document and maintain, a Care Coordination Plan for each enrollee who has been identified as having special health care needs, who does not meet the requirements for referral to Health Home services. If the enrollee is able, the plan must include enrollee participation and, at a minimum:

14.3.6.1 Enrollee self-management goals.

14.3.6.2 Short- and long-term treatment goals, identification of barriers to meeting goals.

14.3.6.3 Identification of barriers to achieving self-management goals and how these were addressed.

14.3.6.4 Time schedule for follow-up treatment and communication with the enrollee.

14.3.6.5 Clinical and non-clinical services accessed by the enrollee or recommended by the primary care provider or care manager.

14.3.6.6 Referrals and as appropriate, funding of community-based self-help programs, such as the Chronic Disease Self Management Education program. The Contractor may choose to fund such programs.

14.3.6.7 Integration and coordination of clinical and non-clinical services, including follow-up to ensure services are accessed (42 C.F.R. § 438.208(c)(2)).

14.3.6.8 Comprehensive medication therapy management services.

14.3.6.9 Modifications as needed to address emerging needs of the enrollee.

14.3.6.10 Progress or reason for lack of progress on self-management goals.

14.3.6.11 Communication with primary and specialty care providers including mental health and substance use disorder providers.

14.3.6.12 A clear description of actions the enrollee's care manager shall take to support the enrollee in meeting the goals of the plan.

14.3.7 For enrollees at high risk of re-hospitalization and/or relapse after substance use disorder treatment, or challenges following the plan of care for mental health conditions, the Contractor shall ensure the enrollee has a documented, individual mental health care plan for interventions to promote recovery and resiliency and mitigate risk. For the purposes of this subsection, "mental health care plan" means a plan that describes the clinical and social supports needed by an enrollee.

14.3.8 The Contractor shall ensure provision of care coordination services including assistance with accessing needed mental health, substance use disorder, physical health services, comprehensive medication therapy management services, oral health services, or community resources.

14.3.8.1 Care coordinators shall monitor, provide referrals to community-based social services and assess referral completion, education, and facilitate and encourage adherence to recommended treatment. Nothing in this requirement should be construed to limit in any way the enrollee's right to refuse treatment.

14.3.9 The Contractor shall develop policies and procedures to govern coordination of assessments and evaluations with mental health, substance use disorder and other providers, and if an enrollee chooses to change enrollment to another AH

plan, the Contractor's care management staff will coordinate transition of the enrollee to the new plan's care management system to ensure services do not lapse and are not duplicated in the transition. The Contractor must also ensure that enrollee confidentiality and enrollee rights are protected (42 C.F.R. § 438.208 (b)(3)).

14.4 **Coordination Between the Contractor and External Entities**

14.4.1 The Contractor shall appropriately coordinate with, and refer as directed, enrollees to the Department of Social and Health Services, Department of Health, local health jurisdictions, community-based service providers and HCA services/programs including but not limited to:

14.4.1.1 HCA First Steps Program - Maternity Support Services (MSS);

14.4.1.2 Transportation and Interpreter Services;

14.4.1.3 Dental services, including the promotion of oral health screening and prevention;

14.4.1.4 Foster Care – Fostering Well-Being program;

14.4.1.5 Regional Support Networks for enrollees with known or suspected serious and persistent mental health conditions;

14.4.1.6 Substance Use Disorder services;

14.4.1.7 DSHS Aging and Long-Term Supports Services Administration (ALTSA) and DSHS Developmental Disability Administration (DDA), including home and community based services;

14.4.1.8 Skilled nursing facilities and community based residential programs;

14.4.1.9 Early Support for Infants and Toddlers;

14.4.1.10 Department of Health and Local Health Jurisdiction services, including Title V services for children with special health care needs;

14.4.1.11 Chronic Disease Self-Management Education; and

14.4.1.12 Qualified Health Homes contracted with HCA.

14.4.2 The Contractor shall participate with, cooperate with and coordinate with regional health alliances, such as the Southwest Washington Regional Health Alliance, Eastern Washington Regional Health Alliance and CHOICE Regional Health Network.

14.4.3 The Contractor shall participate in the management or discussions held at the Bree Collaborative, or with the Foundation for Health Care Quality in their work

on COAP, OB COAP, and SCOAP programs as well as coordinate with other organizations engaged in quality improvement in Washington State.

14.4.4 The Contractor shall join the Puget Sound Health Alliance and actively participate in efforts to improve the quality and efficiency of health care services.

14.4.5 The Contractor shall coordinate enrollee information, including initial assessments and care plans, with other managed care entities as needed when an enrollee changes from one MCO to another, changes from one Health Home lead to another or receives services through an RSN, to reduce duplication of services and unnecessary delays in service provision for enrollees.

14.4.6 For enrollees who receive services through Centers of Excellence (COE) for hemophilia and other bleeding disorders, the Contractor shall coordinate care with the COE to avoid duplication or delays in service provision and factor replacement products and medications to AHMC enrollees. The Contractor shall provide all care coordination and care management services other than those related to management of the enrollee's hemophilia, but will ensure exchange of information necessary to coordinate these services with the COE.

14.4.7 For enrollees who receive services through the University of Washington Bariatric Surgery Center of Excellence (COE), the Contractor shall coordinate care with the COE to avoid duplication or delays in service to AHMC enrollees. The Contractor shall provide all care coordination and care management services other than those related to the enrollee's bariatric surgery, but will ensure exchange of information necessary to coordinate these services with the COE.

14.5 **Transitional Care**

The Contractor shall ensure that transitional care services described in this section are provided to all enrollees who are transitioning from one setting to another. The Contractor shall provide Transitional Care services to enrollees who participate in Health Home services in accord with Exhibit C, Health Homes. The Contractor shall maintain written operational agreements with RSNs. The Contractor shall develop operational agreements with state and community physical and behavioral health hospitals and long-term care facilities by December 31, 2015, to facilitate enrollee care transitions. The written agreements shall define the responsibility of each party in meeting the following requirements:

14.5.1 Completion of a standardized discharge screening tool. The tool shall encompass a risk assessment for re-institutionalization, re-hospitalization, and/or substance use disorder treatment recidivism.

14.5.2 An individual enrollee plan to mitigate the risk for re-institutionalization, re-hospitalization or treatment recidivism to include:

14.5.2.1 Enrollee education that supports discharge care needs including medication management, interventions to ensure follow-up appointments are attended and follow-up for self-management of the enrollee's chronic or acute conditions, including information on when to seek medical care and emergency care. Formal or informal

caregivers shall be included in this process when requested by the enrollee.

14.5.2.2 Written discharge plan provided to both the enrollee and the primary care provider at enrollee discharge;

14.5.2.3 Systematic follow-up protocol to ensure timely access to follow-up care post discharge and to identify and re-engage enrollees that do not receive post discharge care.

14.5.2.4 Scheduled follow-up appointments in place at enrollee discharge;

14.5.2.5 Organized post-discharge services, such as home care services, after-treatment services and therapy services;

14.5.2.6 Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following enrollee discharge;

14.5.2.7 Information on what to do if a problem arises following discharge;

14.5.2.8 For enrollees at high risk of re-hospitalization, a visit by a Contractor designee at the facility before discharge to coordinate transition;

14.5.2.9 For enrollees at high risk of re-hospitalization, primary care provider or Contractor designee visit at the enrollee's residence or secondary facility, such as a skilled nursing facility or residential mental health facility within seven (7) calendar days post-discharge to support: discharge instructions, assess the environment for safety issues, conduct medication reconciliation, assess adequacy of support network and services, and linkage of the enrollee to appropriate referrals;

14.5.2.10 Scheduled outpatient mental health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge; and

14.5.2.11 Planning that actively includes the patient and family caregivers and support network in assessing needs.

14.5.3 The Contractor shall request from enrollees permission to share information with clinical and non-clinical providers to facilitate care transitions.

14.6 **Skilled Nursing Facility Coordination**

14.6.1 The Contractor is responsible for medically necessary Skilled Nursing Facility (SNF) or Nursing Facility (NF) stays when the Contractor determines that nursing facility care is more appropriate than acute hospital care. The Contractor shall coordinate with hospital or other acute care facility discharge planners and

nursing facility care managers or social workers, as described in the Coordination Between the Contractor and External Entities Subsection of this Contract to ensure a smooth transition of the enrollee to or from a SNF or NF.

14.6.2 The Contractor shall coordinate with the SNF or NF to provide care coordination and transitional care and shall ensure coverage of all medically necessary services, prescriptions and equipment not included in the negotiated SNF daily rate. This includes but is not limited to: prescription medications, durable medical equipment, therapies, intravenous medications, and any other medically necessary service or product.

14.6.2.1 If the Contractor, in coordination with the NF or SNF, anticipates the enrollee will be in the facility for additional days after an enrollee no longer meets criteria for medically necessary skilled nursing or rehabilitative care, the Contractor shall coordinate with the Aging and Long-Term Services Administration (ALTSA) Home and Community Services (HCS) to:

14.6.2.1.1 Determine functional, financial and institutional eligibility, if necessary; and

14.6.2.1.2 Assist the enrollee to explore all options available for care, including whether the enrollee will be discharged to his or her home or a community residential setting, or remain in the SNF for long term services and supports (LTSS).

14.6.2.2 If the enrollee is discharged to his or her home or a community residential setting the enrollee remains enrolled in AH. The Contractor shall coordinate with SNF/NF and HCS staff to ensure the enrollee is discharged to a safe location and shall ensure medically necessary services are available to the enrollee including (but not limited to) home health services, durable medical equipment and supplies, outpatient rehabilitation services and any other services necessary to facilitate the enrollee's recovery. The Contractor shall also ensure that follow-up care is provided in accordance with the Transitional Care Coordination requirements of this Contract.

14.6.3 If the enrollee remains in the SNF/NF, the enrollee remains enrolled in AH and ALTSA is responsible for payment of SNF/NF room and board beginning on the date the enrollee is determined not to meet or no longer meets criteria for the rehabilitative or skilled benefit. The MCO continues to be responsible for all medically necessary services, prescriptions, and equipment not included in the ALTSA nursing facility rate. The Contractor shall continue to monitor the enrollee's status and assist in coordination of transitions back to the community.

14.6.4 Issuance of an award letter by ALTSA does not constitute a guarantee or promise of payment for nursing home care.

14.6.5 The Contractor must provide written notice to the facility and the enrollee if the enrollee:

14.6.5.1 Does not meet rehabilitative or skilled nursing criteria; or

14.6.5.2 If a previously authorized stay is being reduced.

The notice must include dates of coverage and the date coverage will end.

14.6.6 For purposes of this Section, “nursing facility level of care” means ongoing support services provided to Medicaid eligible individual in a SNF/NF for enrollees that do not meet the criteria for rehabilitative or skilled nursing services.

14.7 Coordination of Care for Children Eligible for Apple Health Foster Care

14.7.1 The Contractor shall track enrollment of foster children, including those receiving adoption support or in kinship care to ensure adequate coordination of care with the enrollee’s providers and foster parents or guardians.

14.7.2 When HCA determines a child is in foster care or is receiving adoption support services, it shall disenroll the child and transition the child to Apple Health Foster Care.

14.7.3 The Contractor shall coordinate with the Apple Health Foster Care contractor to ensure the child is transitioned to Apple Health Foster Care with minimal disruption in services.

14.8 Care Coordination with Regional Support Networks (RSNs)

14.8.1 The Contractor shall have an operational agreement with all Regional Support Networks (RSNs) operating in the Contactor’s Service Areas that, in addition to Transitional Care, addresses comprehensively the day-to-day operational requirements to coordinate physical and behavioral health care services and fully recognizes the shared responsibility for their mutual enrollees’ health care.

14.8.2 The operational agreement shall address the following areas:

14.8.2.1 Exchange of enrollee health information to include:

14.8.2.1.1 Diagnosis;

14.8.2.1.2 Treatment, including treatment plan;

14.8.2.1.3 Medications;

14.8.2.1.4 Labs/Testing; and

14.8.2.1.5 Treating providers, with contact information.

14.8.2.2 Transitions in care between the Contractor and RSNs, and RSNs and the Contractor.

14.8.2.3 Procedure for evaluation, referral to determine whether the enrollee meets Access to Care Standards (ACS).

14.8.3 The Contractor shall require providers to coordinate with RSN providers and provide all required information to facilitate such coordination.

14.9 Health Home for Individuals with Special Health Care Needs

The Contractor shall establish and implement a Health Home program that meets the requirements of this Section and Exhibit C, Health Homes by becoming a Qualified Health Home or contracting with a Qualified Health Home. The Contractor shall subcontract with organizations such as regional support networks, substance use disorder treatment facilities and long term care agencies, to provide a full range of Health Home services. All enrollees meeting the diagnoses and risk criteria defined by the HCA and identified through the 834 report as Health Home eligible shall be referred to Health Home services.

14.10 Care Coordination Oversight

14.10.1 The Contractor shall have internal monitoring processes in place to ensure compliance with the Care Coordination requirements and the quality and appropriateness of care furnished to individuals with special health care needs. (42 C.F.R. § 438.240 (b)(4)).

14.10.2 Quality assurance reviews of documented care coordination activities provided by the care coordinator shall include assessment of:

14.10.2.1 Case identification and assessment according to established risk identification and assessment systems and timeframes;

14.10.2.2 Documented Care Coordination Plans with evidence of periodic revision as appropriate to the enrollee emerging needs;

14.10.2.3 Effective enrollee monitoring, including management of barriers;

14.10.2.4 Referral management;

14.10.2.5 Effective coordination of care; and

14.10.2.6 Identification of appropriate actions for the care coordinator to take in support of the enrollee, and the care coordinator's follow-through in performing the identified tasks.

14.10.3 The Contractor must document quality assurance reviews and make them available for HCA review.

14.11 Screening Tools

The Contractor shall collaborate with peer Medicaid managed care organizations to define, develop, publish and implement:

14.11.1 Standardized methods to assess:

14.11.1.1 Adverse childhood experiences (ACEs) in children, adolescents and adults, including parents of children;

14.11.1.2 Conduct a provider webinar on the use of screening methods and include a marketing campaign to encourage primary care provider participation (January 1 – June 30, 2015.);

14.11.1.3 Obtain appropriate continuing education certification from the various certification bodies for primary care providers to promote participation in the ACE webinar;

14.11.1.4 Track the names of primary care providers participating in the webinar and calculate the proportion of primary care providers participating in the webinar across all peer Medicaid managed care organizations;

14.11.1.5 Report the proportion of primary care providers participating in the webinar to HCA by December 31, 2015; and

14.11.1.6 Conduct a participant evaluation of the webinar.

14.12 Direct Access for Individuals with Special Health Care Needs

When the required treatment plan of individuals with special health care or children with special health care needs indicates the need for frequent utilization of, a course of treatment with or regular monitoring by a specialist, the Contractor shall allow individuals with special health care needs, whose treatment plan indicates the need for frequent utilization of a specialist, to retain the specialist as a PCP, or alternatively, be allowed direct access, with prior authorization, to specialists for needed care (42 C.F.R. § § 438.208(c)(4) and 438.6(m)).

14.13 Comprehensive Medication Therapy Management Services

14.13.1 The Contractor shall ensure its provider contracts include provider reimbursement methods within the medical billing processes that incentivize pharmacists or other qualified providers licensed in Washington State to provide comprehensive medication management services to targeted individuals, consistent with RCW 74.09.522.

14.13.2 For the purposes of this subsection, “targeted individual” means an enrollee who:

14.13.2.1 Takes four or more prescribed medications (including over-the-counter medications and dietary supplements);

14.13.2.2 Takes any “high risk” medications as defined by NCQA for the HEDIS® Measure: Use of High Risk Medications in the Elderly;

14.13.2.3 Has two or more chronic diseases from the list of conditions measured by CMS as part of the Department of Health and Human Services Multiple Chronic Condition initiative; and

14.13.2.4 Has undergone a transition of care that is likely to create a high risk of medication-related problems.

14.13.3 Comprehensive medication therapy management services includes all of the following:

14.13.3.1 Performing or obtaining necessary assessments of the health and functional status of each patient receiving such comprehensive medication therapy management services;

14.13.3.2 Formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient;

14.13.3.3 Selecting, initiating, modifying, recommending changes to, or administering medication therapy;

14.13.3.4 Monitoring, which may include access to, ordering, or performing laboratory assessments, and evaluating the response of the patient to therapy, including safety and effectiveness;

14.13.3.5 Performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events;

14.13.3.6 Quarterly targeted medication reviews for ongoing monitoring, and additional follow up interventions on a schedule developed collaboratively with the prescriber;

14.13.3.7 Documenting the care delivered and communicating essential information about such care, including a summary of the medication review, and the recommendations of the pharmacist to other appropriate health care providers of the patient in a timely fashion;

14.13.3.8 Providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative;

14.13.3.9 Providing information, designed to enhance patient adherence with therapeutic regimens;

14.13.3.10 Coordinating and integrating comprehensive medication therapy management services within the broader health care management services, including referrals to community-based self-management services, such as the Chronic Disease Self-Management Education program or other social services and resources provided to the patient; and

14.13.3.11 Such other patient care services allowed under pharmacist scopes of practice in use in other Federal programs that have implemented comprehensive medication therapy management services.

14.13.4 The Contractor shall provide an annual report to HCA on the impact of comprehensive medication therapy management services on patient clinical outcomes and total health care costs, including reduction in emergency

department utilization, hospitalization, and drug costs. The report is due to HCA no later than September 1, 2015. HCA will provide a template for the report by March 1, 2015.

15 GENERAL PROVISONS REGARDING BENEFITS

15.1 Second Opinions

15.1.1 The Contractor must authorize a second opinion regarding the enrollee's health care from a qualified health care professional within the Contractor's network, or provide authorization for the enrollee to obtain a second opinion outside the Contractor's network, if the Contractor's network is unable to provide for a qualified health care professional.

15.1.2 This Section shall not be construed to require the Contractor to cover unlimited second opinions, nor to require the Contractor to cover any services other than the professional services of the second opinion provider (42 C.F.R. § 438.206(b)(3)).

15.2 Sterilizations and Hysterectomies

The Contractor shall assure that all sterilizations and hysterectomies performed under this Contract are in compliance with 42 C.F.R. § 441 Subpart F, and that HCA Sterilization Consent Form (HCA 13-364)) or its equivalent is used.

15.3 Narcotic Review

A Contractor's Medical Director or representative shall participate in the Washington HCA Managed Care Medical Director's meeting to develop a process to identify and manage enrollees with a diagnosis of chronic, non-cancer pain taking opioids at a combined daily dose of greater than listed as the maximum in the Agency Medical Directors' Group (AMDG) Opioid Guidelines. Contractor activities developed in collaboration with peer managed care organizations to address this health and safety concern may include, but is not limited to: prescriber and enrollee education about the risk of using high dose opioids, including the provision of opioid dosing guidelines to the prescriber, requesting second opinions from a pain management specialist, preauthorization of all opioid medication, negotiating taper plans with the prescriber resulting in safer dosing levels and referrals to mental health services and/or substance use disorder programs for assessment.

15.4 Special Provisions for American Indians and Alaska Natives

In accord with the Section 5006(d) of the American Recovery and Reinvestment Act of 2009, the Contractor is required to allow American Indians and Alaska Natives free access to and make payments for any participating and nonparticipating Indian health care providers for contracted services provided to American Indian and Alaska Native enrollees at a rate equal to the rate negotiated between the Contractor and the Indian health care provider. If such a rate has not been negotiated, the payment is to be made at a rate that is not less than what would have otherwise been paid to a participating provider who is not an Indian health care provider.

16 BENEFITS

16.1 Scope of Services

16.1.1 The Contractor is responsible for covering medically necessary services to enrollees sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished (42 C.F.R. § 438.210(a)(3)(ii). The Contractor shall cover services related to the following (42 C.F.R. § 438.210(a)(4); WAC 182-501-0060):

16.1.1.1 The prevention, diagnosis, and treatment of health impairments.

16.1.1.2 The achievement of age-appropriate growth and development.

16.1.1.3 The attainment, maintenance or regaining of functional capacity.

16.1.2 If a service is covered by the Health Care Authority under its fee-for-service program as of the date of the execution of this Contract, that service is a contracted service as defined in the Benefits Subsection of this Contract, and shall be provided by the Contractor when medically necessary, including all specific procedures and elements, unless it is specifically excluded under this Contract.

16.1.2.1 For services that the Health Care Authority determines are non-covered or limited in its fee-for-service program, that are not specifically excluded by this Contract, excluded from coverage under Federal regulations or excluded from coverage by the Health Care Authority, the Contractor will have policies and procedures directing that Exception to Rule (ETR) and Limitation Extension (LE) requests be resolved pursuant to the procedures described in WAC 182-501-0169. The Contractor is responsible for providing a service when ETR or LE results in approval of the service.

16.1.3 This Contract does not in any manner delegate coverage decisions to the Contractor. The Contractor must provide the same amount, duration and scope of services as the Health Care Authority fee-for-service program unless a service is specifically excluded. Covered services that are not excluded are contracted services. The Contractor makes the decision whether or not a contracted service is medically necessary. Medical necessity decisions are to be made based on an individual enrollee's healthcare needs by a health care professional with expertise appropriate to the enrollee's condition. The Contractor may not make global medical necessity decisions, since that is a coverage decision. The Contractor is allowed to have guidelines, developed and overseen by appropriate health care professionals, for approving services. All denials of contracted services are to be individual medical necessity decisions made by a health care professional without being limited by such guidelines.

16.1.4 Except as otherwise specifically provided in this Contract, the Contractor shall provide contracted services in the amount, duration and scope described in the

Medicaid State Plan (42 C.F.R. § 438.210(a)(1 & 2)).

16.1.5 The amount and duration of contracted services that are medically necessary depends on the enrollee's condition (42 C.F.R. § 438.210(a)(3)(i)).

16.1.6 The Contractor shall not arbitrarily deny or reduce the amount, duration or scope of required services solely because of the enrollee's diagnosis, type of illness or condition (42 C.F.R. § 438.210(a)(3)(ii).

16.1.7 Except as specifically provided in the provisions of the Authorization of Services Section, the requirements of this Section shall not be construed to prevent the Contractor from establishing utilization control measures as it deems necessary to assure that services are appropriately utilized, provided that utilization control measures do not deny medically necessary contracted services to enrollees nor unduly burden providers or enrollees. The Contractor's utilization control measures are not required to be the same as those in the Medicaid fee-for-service program (42 C.F.R. § 438.210(a)(3)(iii).

16.1.8 For specific contracted services, the requirements of this Section shall also not be construed as requiring the Contractor to provide the specific items provided by the Health Care Authority under its fee-for-service program, but shall rather be construed to require the Contractor to provide the same scope of services.

16.1.9 Nothing in this Contract shall be construed to require or prevent the Contractor from covering services outside of the scope of contracted services (42 C.F.R. § 438.6(e)).

16.1.10 The Contractor may limit the provision of contracted services to participating providers except as specifically provided in this Contract; and the following provisions of this subsection:

16.1.10.1 Emergency services;

16.1.10.2 Outside the Service Areas as necessary to provide medically necessary services; and

16.1.10.3 Coordination of Benefits, when an enrollee has other primary comparable medical coverage as necessary to coordinate benefits.

16.1.11 Within the Service Areas:

16.1.11.1 Within the Contractor's service areas, as defined in the Service Areas provisions of the Enrollment Section of this Contract, the Contractor shall cover enrollees for all medically necessary services included in the scope of services covered by this Contract.

16.1.12 Outside the Service Areas:

16.1.12.1 For the enrollees who are temporarily outside of the service areas or who have moved to a service area not served by the Contractor, the Contractor shall cover the following services:

16.1.12.1.1 Emergency and post-stabilization services.

16.1.12.1.2 Urgent care services associated with the presentation of medical signs that require immediate attention, but are not life threatening. The Contractor may require prior-authorization for urgent care services as long as the wait times specified in the, Appointment Standards provisions of the Access Section of this Contract, are not exceeded.

16.1.12.1.3 Services that are neither emergent nor urgent, but are medically necessary and cannot reasonably wait until enrollee's return to the service area. The Contractor is not required to cover non-symptomatic (i.e., preventive care) out of the service area. The Contractor may require prior-authorization for such services as long as the wait times specified in the Appointment Standards provision of the Access Section of this Contract are not exceeded.

16.1.12.1.4 The Contractor is not responsible for coverage of any services when an enrollee is outside the United States of America and its territories and possessions.

16.2 **Enrollee in Facility at Enrollment**

16.2.1 If an enrollee is in a facility at the time of enrollment and was receiving services through the fee-for-service system on the day he or she was admitted to the facility, the HCA shall be responsible for payment of all facility and professional services provided from the date of admission until the date the enrollee is discharged from a facility to home or a community residential setting.

16.2.2 If an enrollee is enrolled in AH on the day the enrollee was admitted to a facility, the contractor the enrollee is enrolled with on the date of admission shall be responsible for payment of all covered inpatient facility and professional services provided from the date of admission until the date the enrollee no longer meets criteria for the rehabilitative or skilled benefit, or is discharged from a facility to home or a community residential setting, consistent with the Skilled Nursing Facility Coordination Subsection of this Contract.

16.2.3 The payer responsible for payment under this Subsection remains responsible for medical necessity determinations and service authorizations.

16.3 **Enrollee in facility at Termination of Enrollment**

If an enrollee is in a facility at the time of termination of enrollment and the enrollee was enrolled with the Contractor on the date of admission, the Contractor shall be responsible for payment of all covered facility and professional services from the date of admission until one of the following occurs:

16.3.1 The enrollee is discharged from a facility to home or a community residential setting.

16.3.2 The enrollee's eligibility to receive Medicaid services ends. The Contractor's

obligation for payment ends at the end of the month the enrollees Medicaid eligibility ends.

16.3.3 The enrollee no longer meets the Contractor's rehabilitative or skilled criteria.

16.4 **Deliveries and Newborn Coverage**

16.4.1 For newborns born while their mother is hospitalized, the party responsible for the payment of covered services for the mother's hospitalization shall be responsible for payment of all covered inpatient facility and professional services provided to the newborn from the date of admission until the date the enrolled newborn is discharged from the acute care hospital.

16.4.2 If the HCA is responsible for payment of labor and delivery services provided to a mother, the HCA shall not pay the Contractor a Delivery Case Rate under the provisions of the Payment and Sanctions Section of this Contract.

16.4.3 For covered deliveries in a birthing center, the Contractor shall pay for all covered services, including facility costs and professional services provided to the mother and the newborn until the date the enrolled mother and newborn are discharged from the birthing center.

16.4.4 For home deliveries, the Contractor shall pay for all costs associated with the home delivery, including professional services provided to the mother and newborn.

16.5 **General Description of Contracted Services**

16.5.1 The Contractor shall provide a wellness exam to each enrollee that documents the enrollee's baseline health status and allows the enrollee's PCP to monitor health improvements and outcome measures.

16.5.2 When an enrollee has an alcohol and/or chemical dependency and/or mental health diagnosis, the Contractor is responsible for contracted services whether or not the enrollee is also receiving alcohol and/or chemical dependency and/or mental health treatment.

16.5.3 Inpatient Services:

16.5.3.1 Provided by acute care hospitals.

16.5.3.2 Provided by a Nursing Facility, Skilled Nursing Facility or other acute care setting, when services are determined medically necessary and nursing facility services are not covered by DSHS' Aging and Long Term Supports Administration.

16.5.3.3 Consultations with specialty providers, including psychiatric consultations are covered during medical hospital stays.

16.5.3.4 The Contractor shall pay for any and all covered services provided during an inpatient admission even if part of that admission is for mental health services, when the admission didn't occur to a

psychiatric facility or designated psychiatric bed OR the admission wasn't approved by an RSN.

16.5.4 Outpatient Hospital Services: Provided by acute care hospitals.

16.5.5 Emergency Services and Post-stabilization Services:

16.5.5.1 Emergency Services: Emergency services are defined in this Contract.

16.5.5.1.1 The Contractor will provide all inpatient and outpatient emergency services in accord with the requirements of 42 C.F.R. § 438.114.

16.5.5.1.2 The Contractor shall cover all emergency services provided by a licensed provider, acting within their scope of practice, regardless of diagnosis, without regard to whether the provider is a participating or non-participating provider (42 C.F.R. § 438.114 (c)(1)(i)).

16.5.5.1.3 The Contractor shall ensure that an enrollee who has an emergency medical condition is not held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. (42 C.F.R. 438.114(d)(2)).

16.5.5.1.4 The Contractor shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the enrollee's primary care provider or the Contractor of the enrollee's screening and treatment within 10 calendar days of presentation for emergency services (42 C.F.R. § 438.114 (c)(1)(ii)).

16.5.5.1.5 The only exclusions to the Contractor's coverage of emergency services are:

16.5.5.1.5.1 Emergency services for enrollees with a mental health diagnosis, when the emergency room visit results in an inpatient admission to a psychiatric facility/unit; and

16.5.5.1.5.2 Dental services only if provided by a dentist or an oral surgeon to treat a dental diagnosis, covered under HCAs' fee-for-service program.

16.5.5.1.6 Emergency services shall be provided without requiring prior authorization.

16.5.5.1.7 What constitutes an emergency medical condition may not be limited on the basis of lists of diagnoses or symptoms (42 C.F.R. § 438.114 (d)(1)(i)).

16.5.5.1.8 The Contractor shall cover treatment obtained under the following circumstances:

16.5.5.1.8.1 An enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition (42 C.F.R. § 438.114(c)(1)(ii)(A)).

16.5.5.1.8.2 A participating provider or other Contractor representative instructs the enrollee to seek emergency services (42 C.F.R. § 438.114(c)(1)(ii)(B)).

16.5.5.1.8.3 The enrollee presents at the emergency room with a psychiatric diagnosis but is not admitted for inpatient treatment. The Contractor is responsible for all covered psychotropic medications prescribed as a part of the emergency room visit.

16.5.5.1.9 If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor (42 C.F.R. § 438.114 (d)(3)).

16.5.6 Post-stabilization Services:

16.5.6.1 The Contractor will provide all inpatient and outpatient post-stabilization services in accord with the requirements of 42 C.F.R. § 438.114 and 42 C.F.R. § 422.113(c).

16.5.6.2 The Contractor shall cover all post-stabilization services provided by a licensed provider, acting within their scope of practice, without regard to whether the provider is a participating or non-participating provider.

16.5.6.3 The Contractor shall cover post-stabilization services under the following circumstances (42 C.F.R. § 438.114 (e) and 42 C.F.R. § 438.113(c)(2)(iii)):

16.5.6.3.1 The services are pre-approved by a participating provider or other Contractor representative.

16.5.6.3.2 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain the enrollee's stabilized condition within one hour of a request to the Contractor for pre-approval of further post-stabilization care services.

16.5.6.3.3 The services are not pre-approved by a participating provider or other Contractor representative, but are administered to maintain, improve, or resolve the enrollee's stabilized condition and the Contractor does not respond to a request for pre-approval within thirty (30) minutes (RCW 48.43.093(1)(d)), the Contractor cannot be contacted or the Contractor representative and the treating physician cannot reach an agreement concerning the enrollee's care and a Contractor physician is not available for consultation. In this situation, the Contractor shall give the treating physician the opportunity to consult with a Contractor physician and the treating physician may continue with care of the enrollee until a Contractor physician is reached or one of the criteria identified in 42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.133(c)(3) is met.

16.5.6.3.3.1 The Contractor’s responsibility for post-stabilization services it has not pre-approved ends when (42 C.F.R. § 438.114(e) and 42 C.F.R. § 422.133(c)(3)):

16.5.6.3.3.1.1 A participating provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

16.5.6.3.3.1.2 A participating provider assumes responsibility for the enrollee's care through transfer;

16.5.6.3.3.1.3 A Contractor representative and the treating physician reach an agreement concerning the enrollee's care; or

16.5.6.3.3.1.4 The enrollee is discharged.

16.5.7 Ambulatory Surgery Center: Services provided at ambulatory centers.

16.5.8 Provider Services: Services provided in an inpatient or outpatient (e.g., office, clinic, emergency room, pharmacy or home) setting by licensed professionals including, but not limited to, physicians, physician assistants, advanced registered nurse practitioners, naturopaths, pharmacists, midwives, podiatrists, audiologists, registered nurses, and certified dietitians. Provider services include, but are not limited to:

16.5.8.1 Medical examinations, including wellness exams for adults and EPSDT for children.

16.5.8.2 Immunizations, including the varicella zoster (shingles) vaccine for enrollees age sixty (60) and over. For enrollees under age sixty (60), the Contractor may require prior authorization.

16.5.8.3 Pregnant and postpartum clients receive coverage for TDAP vaccine given in any setting (pharmacy, obstetrical provider, etc.) whether or not ordered by PCP.

16.5.8.4 Family planning services provided or referred by a participating provider or practitioner.

16.5.8.5 Performing and/or reading diagnostic tests.

16.5.8.6 Private duty nursing for children age seventeen (17) and younger.

16.5.8.7 Surgical services.

16.5.8.8 Services to correct defects from birth, illness, or trauma, and mastectomy reconstruction.

16.5.8.9 Telemedicine.

16.5.8.10 Anesthesia.

16.5.8.11 Administering pharmaceutical products.

16.5.8.12 Fitting prosthetic and orthotic devices.

16.5.8.13 Rehabilitation services.

16.5.8.14 Enrollee health education.

16.5.8.15 Nutritional counseling by a certified registered dietician for specific conditions such as failure to thrive, feeding problems, cystic fibrosis, diabetes, high blood pressure, and anemia.

16.5.8.16 Bio-feedback training when determined medically necessary.

16.5.8.17 Genetic services, other than prenatal diagnosis and genetic counseling including: testing, counseling and laboratory services, when medically necessary for diagnosis of a medical condition.

16.5.9 Tissue and Organ Transplants: Heart, kidney, liver, bone marrow, lung, heart-lung, pancreas, kidney-pancreas, cornea, small bowel, and peripheral blood stem cell. The MCO shall use the same standards respecting coverage and delivery of the services as the State uses.

16.5.10 Laboratory, Radiology, and Other Medical Imaging Services: Screening and diagnostic services and radiation therapy.

16.5.11 Vision Care: Eye examinations for visual acuity and refraction once every twenty-four (24) months for adults and once every twelve (12) months for children under age twenty-one (21). These limitations do not apply to additional services needed for medical conditions. The Contractor may restrict non-emergent care to participating providers.

16.5.12 Outpatient Mental Health

16.5.12.1 The Contractor shall create a link on the front page of its website for providers and enrollees that directs said providers and enrollees to a mental health website. The mental health website shall:

16.5.12.1.1 Contain information on how to access mental health services;

16.5.12.1.2 Display a current list of contracted mental health professionals; and

16.5.12.1.3 Include information on how to contact the Contractor should the provider or enrollee have difficulty accessing such care.

16.5.12.2 The Contractor shall provide written instructions to its primary care and mental health professionals on how to access and provide mental health services to enrollees. Instructions shall include information on when an enrollee should be referred to the Regional Support Network (RSN) for an evaluation and when the enrollee should receive services from a provider contracted with the Contractor for mental health services.

16.5.12.3 The Contractor shall evaluate an enrollee requesting medically necessary outpatient mental health services to determine whether the enrollee is likely to meet Access to Care Standards (ACS). See

http://www.dshs.wa.gov/pdf/dbhr/mh/PI/Access_to_Care_Standards20060101.pdf

16.5.12.4 If the Contractor determines the enrollee is not likely to meet the ACS, it shall provide all medically necessary outpatient mental health services, including psychiatric and psychological testing, evaluation and diagnosis, treatment and counseling, and medication management as described in this Section.

16.5.12.5 If the Contractor determines the enrollee is likely to meet the ACS, it shall refer the enrollee to the RSN in the enrollee's service area.

16.5.12.6 If the enrollee is referred to the RSN for intake and evaluation, the Contractor shall continue to provide medically necessary outpatient mental health services until the RSN determines whether the enrollee meets the ACS.

16.5.12.7 If the RSN determines the enrollee meets the ACS, the Contractor shall coordinate with the RSN to transition the enrollee to the RSN to ensure continuity of care.

16.5.12.8 If the RSN determines the enrollee does not meet the ACS, the Contractor shall provide all medically necessary outpatient mental health services, including, but not limited to psychiatric and psychological testing, evaluation and diagnosis and medication management as described in this Section.

16.5.12.9 The Contractor shall ensure medication management:

16.5.12.9.1 Provided by the PCP; or

16.5.12.9.2 Provided in conjunction with a mental health professional contracted with the Contractor; or

16.5.12.9.3 Provided by an RSN prescriber. The Contractor shall coordinate medication management with the RSN prescriber; or

16.5.12.9.4 In accord with the requirements of pharmacists under RCW 69.41.190(3); and

16.5.12.9.5 Provided by a pharmacist as part of the comprehensive medication therapy management services, described in this Contract.

16.5.12.10 The Contractor may subcontract with RSNs to provide the outpatient mental health services that are the responsibility of the Contractor. Such contracts shall not be written or construed in a manner that

provides less than the services otherwise described in this Section as the Contractor's responsibility for outpatient mental health services.

16.5.13 Second Opinion for Children Prescribed Mental Health Medications.

16.5.13.1 The Contractor shall coordinate with HCA to obtain a medication consultation by an HCA-approved Second Opinion Network provider (SON) when psychotropic medications or medication regimens for children under eighteen (18) years of age exceed the medication review thresholds established for the HCA Medicaid fee-for-service benefit.

16.5.13.1.1 HCA will provide the Contractor with definitions of age and dose based review thresholds for certain psychotropic medications which must be implemented as claim rejections within the contractor's pharmacy claims processing system.

16.5.13.1.2 For enrollees who have previously filled prescriptions for the same drug at the same daily dosage, the Contractor shall authorize continuation of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON.

16.5.13.1.3 For enrollees who have NOT previously filled prescriptions at the same daily dosage, the Contractor shall deny authorization of psychotropic medications exceeding these review thresholds until receipt of written report containing treatment recommendations from the SON.

16.5.13.1.4 No later than two business days after denial of any psychotropic medication for a child under eighteen (18) years of age, the Contractor shall send notification of authorization denial to applehealthpharmacypolicy@hca.wa.gov. Notification shall include enrollee's name, date of birth, ProviderOne client ID, National Drug Code of the drug denied, prescribed quantity and days' supply, National Provider Identifier of prescriber, name of prescriber, fax or phone number for prescriber, National Provider Identifier of dispensing pharmacy, name of dispensing pharmacy, fax or phone number of dispensing pharmacy, and reason for denial.

16.5.13.1.5 No later than fourteen (14) calendar days following the end of a calendar month the Contractor shall provide a

report in a format as defined by HCA of all utilization of psychotropic medications by enrollees under eighteen (18) years of age. HCA will use this report to initiate second opinion medication reviews for enrollees meeting defined thresholds of psychotropic polypharmacy and therapy duplication.

16.5.13.1.6 Upon receipt of written report from the Second Opinion Network provider, the Contractor shall approve or deny medications according to the recommendations of the SON within five (5) business days.

16.5.13.1.7 Changes to medications or medication regimens which exceed HCA review thresholds and which are not addressed in an existing SON report require the initiation of a new SON review by the Contractor. Reduction of medication doses and / or discontinuation of medications in a psychotropic polypharmacy regimen do not require a new SON.

16.5.13.1.8 Payment to the SON provider for required reviews are the responsibility of HCA according to the provisions of HCA's contract with the SON provider.

16.5.13.1.9 The Contractor is responsible for payment to the prescribing practitioner for time spent engaging in medication review process with the SON.

16.5.13.1.10 To assist prescribers in meeting the needs of Enrollees who are children with a mental health diagnosis, and in order to minimize the need for required medication reviews, the Contractor shall inform network prescribers that HCA provides access to consultation with a child psychiatrist through the Partnership Access Line (PAL). The Contractor is not required to provide payment to prescribers for voluntarily accessing the PAL.

16.5.13.1.11 Changes to the medication review thresholds established by the Medicaid fee-for-service program will be communicated to the Contractor no less than sixty (60) calendar days before any required implementation date.

16.5.14 Neurodevelopmental Services. The Contractor may refer children to a DOH recognized neurodevelopmental center for the services as long as appointment wait time standards and access to care standards of this Contract are met.

16.5.15 Occupational Therapy, Speech Therapy, and Physical Therapy: Services for the restoration or maintenance of a function affected by an enrollee's illness,

disability, condition or injury, or for the amelioration of the effects of a developmental disability if the enrollee is not receiving services from a Department of Health (DOH) recognized neurodevelopmental center.

16.5.16 Pharmaceutical Products:

16.5.16.1 Covered drug products shall include:

16.5.16.1.1 Prescription and over-the-counter drug products according to the Health Care Authority approved formulary. The Contractor's formulary shall include all therapeutic classes covered by the Health Care Authority's fee-for-service Prescription Drug Program, and a sufficient variety of drugs in each therapeutic class to meet enrollees' medically necessary health care needs;

16.5.16.1.2 Antigens and allergens;

16.5.16.1.3 Therapeutic vitamins and iron prescribed for prenatal and postnatal care;

16.5.16.1.4 Insulin Pens without requiring authorization and approval for:

16.5.16.1.4.1 Pregnant women; and

16.5.16.1.4.2 Children under age 21.

16.5.16.1.5 Psychotropic medications according to the contractor's approved formulary when prescribed by a medical or mental health professional, when he or she is prescribing medications within his or her scope of practice with appropriate.

16.5.16.1.6 Hemophiliac Blood Product – Blood factors VII, VIII, and IX and the anti-inhibitor provided to enrollees with a diagnosis of hemophilia or von Willebrand disease when the enrollee is receiving services in an inpatient setting.

16.5.16.1.7 All Food and Drug Administration (FDA) approved contraceptive drugs, devices, and supplies, including emergency contraception, all long acting reversible contraceptives, all over-the-counter (OTC) contraceptives and contraceptive methods which require administration or insertion by a health care professional in a medical setting. Coverage of contraceptive drugs, devices and supplies must include:

16.5.16.1.7.1 All OTC contraceptives without a prescription. This includes but is not limited to condoms, spermicides, sponges and any emergency contraceptive drug that is FDA-approved to be dispensed over the counter. There are no limits to these OTC contraceptives. OTC contraceptives must be covered without authorization or quantity limits.

16.5.16.1.7.2 Coverage when dispensed by either a pharmacy or a Family Planning Clinic at the time of a family planning visit. Contraceptives dispensed by a Family Planning Clinic must be covered under the medical benefit.

16.5.16.1.7.3 Dispensing of 12 months of contraceptives at one time without authorization requirements related to quantity or days supplied. Duration of any authorization for contraceptives for other reasons must be no less than 12 months.

16.5.16.1.7.4 Contraceptive dispensing in twelve (12) month supplies unless otherwise prescribed by the clinician or the enrollee requests a smaller supply.

16.5.16.1.7.5 Encourage prescribers to write contraception prescriptions for dispensing in twelve (12) month supplies and pharmacists to dispense in twelve (12) month supplies.

16.5.16.1.7.6 Appropriate prescribing and dispensing practices in accord with clinical guidelines to ensure the health of the enrollee while maximizing access to effective birth control methods or contraceptive drugs.

16.5.16.2 Coverage of Mental Health Medications

16.5.16.2.1 Failure to cover mental health drugs as described in this subsection may result in sanctions as described in the Sanctions Subsection of this Contract.

16.5.16.2.2 The Contractor's formulary shall be identical to the Washington Preferred Drug List for antipsychotic medications including HCA's generic first requirements.

16.5.16.2.3 The Contractor shall make exceptions to refill-too-soon requirements for any medication dispensed to enrollees, admitted to a psychiatric residential treatment center or to any enrollee when it is medically necessary to do so.

16.5.16.2.4 Coverage Limitations

16.5.16.2.4.1 The Contractor shall not place any coverage limitations including quantity, dose, indication, duration, or duplication of therapy on antipsychotics, antidepressants or medications to treat Attention Deficit Hyperactivity Disorder (ADHD) without the written authorization of HCA.

16.5.16.2.4.2 The Contractor shall submit coverage limitations and any proposed changes to existing coverage limitations to HCA for approval before implementation.

16.5.16.2.5 Indefinite continuation of therapy for the following mental health drugs.

16.5.16.2.5.1 Drugs that have an FDA-approved indication for treatment of ADHD that have been previously prescribed for an enrollee 21 years of age or younger, regardless of the drug's status on the contractor's formulary.

16.5.16.2.5.2 Antipsychotic and antidepressant medications that an enrollee has been previously prescribed, regardless of the drug's status on the Contractor's formulary.

16.5.16.2.6 The Contractor shall authorize continuation of therapy based on an oral or written statement from a pharmacist or prescribing provider or his or her delegate. Chart notes shall not be required for authorization of continuation of therapy.

16.5.16.3 The Contractor shall provide online access to its formulary and coverage criteria to participating pharmacies and participating

providers and to enrollees and potential enrollees. The online formulary shall be easy to access and the website in which it is situated will be designed to use easily understandable language.

16.5.16.4 The Contractor shall have in place a mechanism to deny prescriptions written:

16.5.16.4.1 By excluded providers;

16.5.16.4.2 From non-rebate eligible manufacturers; and

16.5.16.4.3 For non-medically accepted indications.

16.5.16.5 Emergency supply of medication

16.5.16.5.1 The Contractor shall have a process for providing an emergency drug supply to enrollees when a delay in authorization would interrupt a drug therapy that must be continuous or when the delay would pose a threat to the enrollee's health and safety. The drug supply provided must be sufficient to bridge the time until an authorization determination is made.

16.5.16.5.2 The Contractor shall have a process for authorization after the fact of an emergency fill as defined in this Contract when an emergency fill of a medication is dispensed according to the professional judgment of the dispensing pharmacist not to exceed thirty (30) days supply. The authorization for the prescription must match the drug quantity and days supplied as dispensed by the pharmacist.

16.5.16.6 The Contractor shall have a Drug Use Review program that ensures providers screen for allergies, idiosyncrasies, chronic conditions that may relate to drug utilization, potential drug therapy problems, and provide counseling to the enrollee in accordance with existing state pharmacy laws and federal regulations.

16.5.16.7 Drug Rebate Requirements

16.5.16.7.1 Section 2501 (c) of the Patient Protection and Affordable Care Act (ACA) expanded the drug rebate requirement to include drugs dispensed to enrollees. Covered outpatient drugs dispensed by the Contractor to enrollees, including those administered by physicians in their offices, are subject to the same manufacturer rebate requirements as HCA's fee-for-service outpatient drugs.

16.5.16.7.2 The Contractor is subject to requirements for rebate agreements as defined in Section 1927 of the Social Security Act found at: http://www.ssa.gov/OP_Home/ssact/title19/1927.htm

16.5.16.7.3 The Contractor shall ensure that:

16.5.16.7.3.1 Products in the Contractor's drug formulary are purchased from a participating rebate eligible manufacturer as defined in this Contract. A list of eligible manufacturers can be found at: **http://www.hca.wa.gov/medicaid/pharmacy/Documents/rebate_customer_list.pdf**;

16.5.16.7.3.2 Bulk chemicals used in the compounding of medications are exempt from the federal rebate requirements.

16.5.16.7.3.3 Drug rebate records are kept in accord with the Records Retention section of this contact and are made available to HCA upon request.

16.5.17 Non-pharmaceutical birth control products, including:

16.5.17.1 ParaGard® (T 380A);

16.5.17.2 Fertility awareness-based methods, such as cycle beads, basal body temperature thermometers, and charts; and

16.5.17.3 Essure sterilization method.

16.5.18 Enteral and parenteral nutritional supplements and supplies, including prescribed infant formulas.

16.5.19 Home Health Services: Home health services through state-licensed agencies.

16.5.20 Durable Medical Equipment (DME) and Supplies and any applicable sales tax including, but not limited to: DME; surgical appliances; orthopedic appliances and braces; prosthetic and orthotic devices; breast pumps; incontinence supplies for enrollees over three (3) years of age; and medical supplies. Incontinence supplies shall not include non-disposable diapers unless the enrollee agrees. The Contractor shall consult with the Washington State Department of Revenue for guidance on the applicable sales tax.

16.5.21 Respiratory Care: Equipment, services and supplies.

16.5.22 Hospice Services: Includes services for adults and children and provided in

Skilled Nursing Facilities/Nursing Facilities, hospitals, hospice care centers and the enrollee's home. Hospice services include:

16.5.22.1 Pediatric Palliative Care.

16.5.22.2 Pediatric Concurrent Care.

16.5.23 Blood, Blood Components and Human Blood Products: Administration of whole blood and blood components as well as human blood products. In areas where there is a charge for blood and/or blood products, the Contractor shall cover the cost of the blood or blood products.

16.5.24 Treatment for Renal Failure: Hemodialysis, or other appropriate procedures to treat renal failure, including equipment needed in the course of treatment.

16.5.25 Ambulance Transportation: The Contractor shall cover ground ambulance transportation for emergency medical conditions, as defined in this subsection. For ambulance purposes, "emergency medical conditions" include psychotic episodes necessitating ambulance transportation of a mentally ill client to an evaluation and treatment facility. Covered ground ambulance services include Basic and Advanced Life Support (BLS and ALS) Services, Specialty Care Transport (SCT) and other required transportation costs, such as tolls, fares and extra attendant. In addition, the Contractor shall cover ambulance services under two circumstances for non-emergencies:

16.5.25.1 When it is necessary to transport an enrollee between facilities to receive a contracted service; and

16.5.25.2 When it is necessary to transport an enrollee, who must be carried on a stretcher, or who may require medical attention en route (RCW 18.73.180) to receive a covered service.

16.5.26 Smoking Cessation Services without primary care provider referral or Contractor prior authorization.

16.5.27 Newborn Screenings: The Contractor shall cover all newborn screenings required by the Department of Health.

16.5.28 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(b), 1396d(r)):

16.5.28.1 The Contractor shall meet all requirements under the Social Security Act (SSA) Section 1905(r) and Health Care Authority EPSDT program policy.

16.5.28.1.1 Covered screening services include, but are not limited to: a complete health and developmental history that assess for physical and mental health, developmental and substance use disorder conditions, a comprehensive, unclothed physical exam, immunizations according to age and health history, laboratory tests, including appropriate blood lead screening, health education and anticipatory guidance for both the child

and caregiver, and screenings for: vision, dental, substance use conditions, mental health and hearing.

16.5.28.1.2 The Contractor shall conduct outreach efforts with enrollees to promote completion of EPSDT services and may implement enrollee and primary care provider incentives to ensure that enrollees under the age of 21 receive screening services at least as frequently as the periodicity requirements for such services established by HCA. Screening services are also covered at other times, when medically necessary (42 U.S.C. § 1396(r)(1)).

16.5.28.1.3 Diagnostic and treatment services include vision, dental and hearing services, as well as any other services prescribed to correct or ameliorate physical, mental, psychological, medical, developmental or other health conditions discovered by and determined to be medically necessary by a qualified health care provider acting within his or her scope of practice (42 U.S.C. § 1396(r)(2)-(5)).

16.5.28.1.4 The Contractor shall be responsible for all EPSDT screening, diagnostic, and treatment services found to be medically necessary during the EPSDT exam. HCA has determined that EPSDT is available to and shall be covered by the Contractor for all children eligible for any of its medical programs. The Contractor may apply utilization management requirements to screening, diagnostic and treatment services identified as a need during an EPSDT examination.

16.5.28.2 If a service is determined to be medically necessary through EPSDT, the Contractor will provide the service, whether or not it is a contracted service, unless it is specifically excluded or prohibited by Federal rules. ETR and LE rules shall apply in these circumstances.

16.5.28.3 If a child with special health care needs is assigned to a specialist for primary care, the assigned specialist is responsible for ensuring the child receives EPSDT services.

16.5.28.4 The Contractor may enter into contractual agreements with school-based health centers and family planning clinics to promote delivery of EPSDT services to adolescents accessing such services. Such contracts shall:

16.5.28.4.1 Require providers to follow EPSDT requirements;

16.5.28.4.2 Coordinate identified needs for specialty care, such as referrals for vision or mental health evaluation and

treatment services with the adolescent's primary care provider;

16.5.28.4.3 Not deny payment for EPSDT services delivered by more than one provider (primary care provider, school-based provider or family planning clinic) within a calendar year;

16.5.28.4.4 Ensure the policies and procedures for accessing such services by contracting school-based health centers and family planning clinics are compliant with applicable federal and state statutes; and

16.5.28.4.5 The Contractor shall coordinate with school-based health centers and other appropriate entities to assure activities performed by the Contractor are not duplicated.

16.5.28.5 The Contractor shall follow the guidelines found at the following website: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-and-Periodic-Screening-Diagnostic-and-Treatment.html.

16.5.29 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair: For enrollees age 20 and younger.

16.5.30 Bilateral Cochlear Implants, including implants, including parts, accessories, batteries, chargers, and repairs: For enrollees age 20 and younger.

16.5.31 Bone-Anchored Hearing Aids (BAHA), including BAHA devices (both surgically implanted and soft band headbands), replacement parts, and batteries: For enrollees age 20 and younger. .

16.5.32 Services to Inmates of City and County Jail Facilities: The Contractor shall provide inpatient hospital services to enrollees who are inmates of a city or county jail facility when an inpatient admission occurs during the first month of the incarceration period and HCA has paid a premium for that month to the Contractor. The Contactor's existing policies about establishing medical necessity for the inpatient admission and procedure(s) may be applied, even retrospectively, to determine payment.

16.5.33 Habilitative Services: Limited to enrollees in the Medicaid expansion population that are eligible for the Alternative Benefit Plan (ABP). Devices for adults and children provided for this purpose are covered under the DME benefit.

16.5.33.1 For Children: No limitation.

16.5.33.2 For Adults: Twenty-four (24) units each for physical and occupational therapy and six (6) units of speech therapy, subject to limitation extensions as determined medically necessary.

16.5.33.3 Habilitative services do not include:

16.5.33.3.1 Day habilitation services designed to provide training, structured activities and specialized services to adults;

16.5.33.3.2 Chore services to assist with basic needs;

16.5.33.3.3 Vocational services;

16.5.33.3.4 Custodial services;

16.5.33.3.5 Respite care;

16.5.33.3.6 Recreational care;

16.5.33.3.7 Residential treatment;

16.5.33.3.8 Social services; and

16.5.33.3.9 Educational services.

16.5.34 Screening, Brief Intervention and Referral to Treatment (SBIRT) services for adolescents and adults known to be or are at high risk for substance abuse, to include alcohol and drugs with or without anxiety or depression. SBIRT activities for identifying and reducing risk in individuals with drug or alcohol use concerns shall be one of the screening tools/interventions selected. Included as part of this effort are screens for depression and anxiety.

16.5.35 Comprehensive Medication Therapy Management Services.

16.5.36 Surgical procedures for weight loss or reduction consistent with WAC 182-531-1600.

16.5.37 Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by JCAHO.

16.5.38 Medically necessary treatment for complications resulting from an excluded service.

16.6 **Enrollee Self-Referral**

16.6.1 Enrollees have the right to self-refer for certain services to participating or nonparticipating local health departments and participating or nonparticipating family planning clinics paid through separate arrangements with the State of Washington.

16.6.2 The Contractor is not responsible for the coverage of the services provided through such separate arrangements.

16.6.3 The enrollees also may choose to receive such services from the Contractor.

16.6.4 The Contractor shall assure that enrollees are informed, whenever appropriate, of all options in such a way as not to prejudice or direct the enrollee's choice of where to receive the services. If the Contractor in any manner deprives enrollees of their free choice to receive services through the Contractor, the Contractor shall pay the local health department or family planning facility for services provided to enrollees up to the limits described herein.

16.6.5 The Contractor shall make a reasonable and fair effort to subcontract with all

local health departments, school-based health centers, family planning agencies contracted with HCA, and Indian Health Service (IHS), Indian Tribe, Tribal Organization, and Urban Indian Organization (I/T/U) providers.

16.6.6 If the Contractor subcontracts with local health departments, school-based health centers, family planning clinics or Indian Health Service (IHS), Indian Tribe, Tribal Organization, and Urban Indian Organization (I/T/U) providers as participating providers or refers enrollees to them to receive services, the Contractor shall pay the provider for services provided up to the limits described in this Contract.

16.6.7 The services to which an enrollee may self-refer are:

16.6.7.1 Family planning services and sexually-transmitted disease screening and treatment services provided at participating or nonparticipating providers, including but not limited to family planning agencies, such as Planned Parenthood.

16.6.7.2 Immunizations, sexually-transmitted disease screening and follow-up, immunodeficiency virus (HIV) screening, tuberculosis screening and follow-up, and family planning services through and if provided by a local health department.

16.6.7.3 Immunizations, sexually transmitted disease screening, family planning and mental health services through and if provided by a school-based health center.

16.6.7.4 All services received by American Indian or Alaska Native enrollees under the Special Provisions for American Indians and Alaska Natives Subsection of this Contract.

16.7 **Exclusions**

The following services and supplies are excluded from coverage under this Contract.

16.7.1 Unless otherwise required by this Contract, ancillary services resulting solely from or ordered in the course of non-contracted services are also non-contracted services.

16.7.2 The Contractor shall not provide services that violate the Assisted Suicide Funding Restriction Act of 1997(1903(i);1903(i)(16)).

16.7.3 Early, elective inductions (before 39 weeks) that do not meet medically necessary indicators set by JCAHO. Because JCAHO criteria do not capture all situations in which an early delivery is medically indicated, the Contractor shall provide a process for facilities to request a review of cases that do not meet JCAHO criteria, but which the hospital and delivering provider believe were medically necessary.

16.7.4 The following covered services are provided by the State and are not contracted services. The Contractor is responsible for coordinating and referring enrollees to these services through all means possible, e.g., action letter notices, call center communication or Contractor publications.

16.7.4.1 Inpatient services at Certified Public Expenditure (CPE) hospitals for Categorically Needy – Blind and Disabled identified by the Health Care Authority;

16.7.4.2 School-based Health Care Services for Children in Special Education with an Individualized Education Plan or Individualized Family Service Plan who have a disability, developmental delay or are diagnosed with a physical or mental condition;

16.7.4.3 Eyeglass frames, lenses, and fabrication services covered under the Health Care Authority's selective contract for these services, and associated fitting and dispensing services. The Contractor is encouraged to inform eye practitioners of the availability of Airway Heights Correctional Center to access glasses for clients if not offered by the Contractor as a value added benefit;

16.7.4.4 Voluntary Termination of Pregnancy;

16.7.4.5 Court-ordered transportation services, including ambulance services;

16.7.4.6 Transportation Services other than ambulance, including but not limited to: taxi, cabulance, voluntary transportation, public transportation and common carriers;

16.7.4.7 Air ambulance services. The Contractor remains responsible for all ground ambulance transportation services as described in this Contract;

16.7.4.8 Services provided by dentists and oral surgeons for dental diagnoses; anesthesia for dental care;

16.7.4.9 Orthodontics;

16.7.4.10 Monaural and binaural hearing aids, including fitting, follow-up care, batteries, and repair for enrollees over age 20;

16.7.4.11 HCA First Steps Program - Maternity Support Services (MSS), consistent with the Marketing and Information, Subcontracts, and Care Coordination provisions of this Contract;

16.7.4.12 Sterilizations for enrollees under age twenty-one (21), or those that do not meet other federal requirements (42 C.F.R. § 441 Subpart F);

16.7.4.13 Health care services provided by a neurodevelopmental center recognized by the Department of Health;

16.7.4.14 Services provided by a health department when a client self-refers for care if the health department is not contracted with the Contractor;

16.7.4.15 Inpatient psychiatric services, including psychiatric consultations approved and paid for by Regional Support Networks;

16.7.4.16 Long-term private duty nursing for enrollees 18 and over. These services are covered by DSHS, Aging and Long-Term Services Administration;

16.7.4.17 Prenatal Diagnosis Genetic Counseling provided to enrollees to allow enrollees and their PCPs to make informed decisions regarding current genetic practices and testing;

16.7.4.18 Substance use treatment services covered through the DSHS, Behavioral Health and Service Integration Administration (BHSIA);

16.7.4.19 Community-based services (e.g., COPES and Personal Care Services) covered through the Aging and Long Term Services Administration (ALTSA);

16.7.4.20 Nursing facility stays that do not meet rehabilitative or skilled criteria;

16.7.4.21 Mental health services separately purchased for all Medicaid clients by the DSHS, BHSIA;

16.7.4.22 Health care services covered through the DSHS, Developmental Disabilities Administration (DDA) for institutionalized clients;

16.7.4.23 Infant formula for oral feeding provided by the Women, Infants and Children (WIC) program in the Department of Health. Medically necessary nutritional supplements for infants are covered under the pharmacy benefit;

16.7.4.24 Any service provided to an enrollee while incarcerated with the Washington State Department of Corrections (DOC);

16.7.4.25 Hemophiliac Blood Product – Blood factors VII, VIII and IX and the anti-inhibitor indicated for use in treatment for hemophilia and von Willebrand disease distributed for administration in the enrollee's home or other outpatient setting; and.

16.7.4.26 Immune modulators and anti-viral medications to treat Hepatitis C. This exclusion does not apply to any other contracted service related to the diagnosis or treatment of Hepatitis C.

16.8 **Coordination of Benefits and Subrogation of Rights of Third Party Liability**

16.8.1 Coordination of Benefits:

16.8.1.1 Until the HealthCare Authority ends the enrollment of an enrollee who has comparable coverage as described in the Enrollment Section of

this Contract, the services and benefits available under this Contract shall be secondary to any other medical coverage.

16.8.1.2 Nothing in this Section negates any of the Contractor's responsibilities under this Contract including, but not limited to, the requirement described in the Prohibition on Enrollee Charges for Contracted Services provisions of the Enrollee Rights and Protections Section of this Contract. The Contractor shall:

16.8.1.2.1 Not refuse or reduce services provided under this Contract solely due to the existence of similar benefits provided under any other health care contracts (RCW 48.21.200), except in accord with applicable coordination of benefits rules in WAC 284-51.

16.8.1.2.2 Attempt to recover any third-party resources available to enrollees (42 C.F.R. § 433 Subpart D) and shall make all records pertaining to coordination of benefits collections for enrollees available for audit and review.

16.8.1.2.3 Pay claims for prenatal care and preventive pediatric care and then seek reimbursement from third parties (42 C.F.R. § 433.139(b)(3)).

16.8.1.2.4 Pay claims for contracted services when probable third party liability has not been established or the third party benefits are not available to pay a claim at the time it is filed (42 C.F.R. § 433.139(c)).

16.8.1.2.5 Coordinate with out-of-network providers with respect to payment to ensure the cost to enrollees is no greater than it would be if the services were furnished within the network.

16.8.1.2.6 Communicate the requirements of this Section to subcontractors that provide services under the terms of this Contract, and assure compliance with them.

16.8.2 Subrogation Rights of Third-Party Liability:

16.8.2.1 Injured person means an enrollee covered by this Contract who sustains bodily injury.

16.8.2.2 Contractor's medical expense means the expense incurred by the Contractor for the care or treatment of the injury sustained computed in accord with the Contractor's fee-for-service schedule.

16.8.2.3 If an enrollee requires medical services from the Contractor as a result of an alleged act or omission by a third-party giving rise to a

claim of legal liability against the third-party, the Contractor shall have the right to obtain recovery of its cost of providing benefits to the injured person from the third-party.

16.8.2.4 The Health Care Authority specifically assigns to the Contractor the Health Care Authority's rights to such third party payments for medical care provided to an enrollee on behalf of the Health Care Authority, which the enrollee assigned to the Health Care Authority as provided in WAC 182-503-0540.

16.8.2.5 The Health Care Authority also assigns to the Contractor its statutory lien under RCW 41.05A.070. The Contractor shall be subrogated to the Health Care Authority's rights and remedies under RCW 74.09.180 and 41.05A.050 through 41.05A.080 with respect to medical benefits provided to enrollees on behalf of the Health Care Authority under Chapter 74.09 RCW.

16.8.2.6 The Contractor may obtain a signed agreement from the enrollee in which the enrollee agrees to fully cooperate in effecting collection from persons causing the injury. The agreement may provide that if an injured party settles a claim without protecting the Contractor's interest, the injured party shall be liable to the Contractor for the full cost of medical services provided by the Contractor.

16.8.2.7 The Contractor shall notify the Health Care Authority of the name, address, and other identifying information of any enrollee and the enrollee's attorney who settles a claim without protecting the Contractor's interest in contravention of RCW 41.05A.060.

16.9 **Patient Review and Coordination (PRC)**

16.9.1 The Contractor shall have a PRC program that meets the requirements of WAC 182-501-0135. PRC is authorized by 42 U.S.C. § 1396n (a)(2) and 42 C.F.R. § 431.54.

16.9.2 If either the Contractor or the Health Care Authority places an enrollee into the PRC program, both parties will honor that placement.

16.9.3 The Contractor’s placement of an enrollee into the PRC program shall be considered an action, which shall be subject to appeal under the provisions of the Grievance System section of this Contract. If the enrollee appeals the PRC placement the Contractor will notify the Health Care Authority of the appeal and the outcome.

16.9.4 When an enrollee is placed in the Contractor’s PRC program, the Contractor shall send the enrollee a written notice of the enrollee’s PRC placement, or any change of status, in accord with the requirements of WAC 182-501-0135.

16.9.5 The Contractor shall send the Health Care Authority a written notice of the enrollee’s PRC placement, or any change of status, in accord with the required format provided in the Patient Review and Coordination Program Guide

published by the Health Care Authority.

16.9.6 The Contractor shall ensure PRC clients and providers have direct access to the Contractor's PRC-trained program staff to make needed changes to assigned providers during regular business hours. The Contractor may also subcontract to provide this service.

16.9.7 For an enrollee admitted to a residential treatment center, the Contractor shall allow a representative of the center to make changes to assigned providers, including pharmacies, on the enrollee's behalf without the enrollee's written or oral consent.

16.9.8 In accord with WAC 182-501-0135, the Health Care Authority will limit the ability of an enrollee placed in the PRC program to change their enrolled contractor for twelve months after the enrollee is in the PRC program by the Health Care Authority or the Contractor unless the PRC enrollee moves to a residence outside the Contractor's service areas or if the enrollee is admitted to a subacute mental health facility. The Contractor shall allow for a temporary change in PCP or pharmacy for the enrollee. The Contractor shall accept notification from the facility of the change in enrollee status and the need for a newly assigned PCP and pharmacy. The temporary change in providers is effective until the date of discharge from the facility.

16.9.9 If the Health Care Authority limits the ability of an enrollee to change their enrolled contractor family members may still change enrollment as provided in this Contract.